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MAXIMIZING SUPPORTIVE SERVICES FOR THE ELDERLY IN ASSISTED HOUSING: EXPERIENCES FROM THE CONGREGATE HOUSING SERVICES PROGRAM

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HEARING

BEFORE THE

SUBCOMMITTEE ON
HOUSING AND CONSUMER INTERESTS

OF THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

FIRST SESSION

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MAXIMIZING SUPPORTIVE SERVICES FOR THE ELDERLY IN ASSISTED HOUSING: EXPERIENCES FROM THE CONGREGATE HOUSING SERVICES PROGRAM

WEDNESDAY, OCTOBER 2, 1985

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON AGING,
SUBCOMMITTEE ON HOUSING AND CONSUMER INTERESTS,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:10 a.m., in room 2212, Rayburn House Office Building, Hon. Don Bonker (chairman of the subcommittee) presiding.

Members present: Representatives Bonker, Lloyd, Wortley, and Schuette.

Also present: Representative Vento.

Staff present: Michael Rodgers, staff director; Susan Able, staff assistant; Gretchen Sorensen, research assistant; and Jan Porush, minority staff assistant.

OPENING STATEMENT OF CHAIRMAN DON BONKER

Mr. BONKER. The subcommittee will come to order.

Good morning.

The Subcommittee on Housing and Consumer Interests today is conducting an oversight hearing, the purpose of which is to examine the current status of the Congregate Housing Services Program. In recent years this program has taken on increased importance as public policymakers continue to search for new options to deal with the complex issues that are associated with community-based long-term care.

As a nation, we have always been committed to certain goals which enhance the quality of life for our older citizens. That includes such things as dignity, independence, and the idea of having some options in terms of living opportunities. These are all well established goals. But in an effort to achieve them, we need to create programs that will assure adequate income and quality health care, and we also need to look at the other services that are designed to improve the well-being of older citizens. Certainly safe and affordable housing is very integral to that well established goal.

The concepts that have been embodied in congregate housing services represent a hopeful alternative. Simply stated, the mission of congregate housing is to provide environments that encourage

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support to a maximum degree of the independent. The idea is to make it unnecessary for the elderly to seek refuge in medically oriented facilities that really provide more services than are necessary and in many cases far more costly services, often resulting in a loss of personal autonomy and ultimately the well-being of the person may be impaired. So we go back to the whole notion of congregate housing which is not entirely a new concept

What we need to do today is examine the progress that we have had to date, or the lack of progress, and to focus continued attention on a program which I believe holds the promise for ultimately reducing the costs associated with institutionally based long-term care. At the very least, we wish to highlight the fact that congregate housing services represent a holistic and rational approach to providing care to the elderly.

It is my hope that the hearing today will provide us with information on both the effectiveness and the efficiency of the Congregate Housing Services Program in meeting the needs of today's elderly. We will also be talking to Mr. Beirne about the so-called evaluation which was mandated by Congress in the last session concerning the Congregate Housing Services Program and where that evaluation is now placed within the administration's review.

So, hopefully, Mr. Beirne, you will be prepared to respond to questions in that area.

[The prepared statement of Chairman Bonker follows:]

PREPARED STATEMENT OF CHAIRMAN DON BONKER

Good morning. Today, the Subcommittee on Housing and Consumer Interests of the Select Committee on Aging is convening an oversight hearing to examine the current status of the Congregate Housing Services Program. In recent years this program has taken on increased importance as public policy has searched for new options to deal with the complex issue of community long-term care.

As a nation, we have always been committed to certain goals which would enhance the quality of life for our older citizens. Dignity, independence, and the exercise of options are among the most important of these goals. In an effort to achieve them, we have created programs to assure adequate income, quality health care, and other access services designed to enhance the well being of our older citizens. Certainly, safe affordable housing must be counted as a major part of such intervention.

The history of assisted housing in this country is a rich one. At present some 3½ million persons reside in assisted housing throughout this nation—nearly half are elderly.

Although our experience in assisted housing spans some 50 years, we have only recently discovered that the shelter needs of older persons extend beyond the traditional "brick and mortar" approach. Studies clearly demonstrated that a large portion of older tenants in public and Section 202 housing are literally "aging in place." Today, a recognition has emerged that many of America's elderly with mild impairments are struggling against almost insurmountable odds to continue to live independently, and to find the services and opportunities they need to prevent further deterioration and social isolation.

For these older persons, the concepts embodied in Congregate Housing Services represent a hopeful alternative. Simply stated, the mission of congregate housing is to provide environments that encourage and support a maximum degree of independence. It is designed to make it unnecessary for the elderly to seek refuge in medically oriented facilities that provide more services than required—refuge that often results in a loss of personal autonomy, and ultimately the will to prevail.

Congregate Housing is not an entirely new concept. This Subcommittee first examined this program back in 1981, shortly after the start of the Department of Housing and Urban Development's demonstration program. Additionally, ten years ago, the First National Conference on Congregate Housing for Older People, was held here in Washington, under the auspices of the International Center for Social

Gerontology. During that conference, a number of important and excellent papers on issues surrounding congregate housing were presented. It is not surprising that many of those papers have wide applicability even today.

The purpose of this hearing, then, is to examine our progress to date, and to focus continued attention on a program which—I believe—holds the promise for ultimately reducing the costs associated with institutionally based long-term care. At the very least, we wish to highlight the fact that congregate housing services represent a more wholistic and rational approach to providing care to the frail elderly.

There is one other issue which I think needs to be mentioned this morning, and clearly deserves our attention. That is, the significant demographic projections on ther horizon—the greying of our population. The dramatic impact that the increase in the older population will have on American society will signal important changes for the future.

We know that there will be more older people, both absolutely and relative to the rest of the population. But it is not the explosive growth of the 65 and older population that is most significant. Instead, it is the "oldest of the old"—those 85 and up—which is growing faster and will deserve our special attention. Clearly, our country will be faced with tremendous challenges in providing housing, health care and supportive services to more people over a longer period of time. It is equally clear that the development of sound public policy will require the development of a wide spectrum of "models" for meeting these human needs. In my estimation, congregate housing services, should be one model in that spectrum.

It is my hope that the hearing today will provide us with information on both the effectiveness and efficiency of the congregate housing service program in meeting the needs of today's elderly. I look forward to hearing the comments of our witnesses as to what we can and should do now and in the future to responsively meet the shelter needs of America's aged.

Mr. BONKER. We are pleased to have an excellent panel today that will consist of Mr. Kenneth Beirne, who represents the administration, and then five witnesses will comprise a panel representing the nonfederal areas interested in this subject.

We shall proceed, as usual, with our lead-off witness who today is Kenneth Beirne. He is the general deputy assistant secretary, Office of Policy Development and Research in the Department of Housing and Urban Development.

Mr. Beirne, we are very pleased to have you come before the committee. We are looking forward to your testimony; and if you want to submit the statement for the record, it will be included in its entirety. If you want to summarize your remarks, that will be fine too. I will have some questions and if other members of the committee show up this morning, which I hope they will, I am sure they will have questions as well.

You may proceed.

STATEMENT OF KENNETH J. BEIRNE, GENERAL DEPUTY ASSISTANT SECRETARY FOR POLICY DEVELOPMENT AND RESEARCH, DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

Mr. BEIRNE. Thank you very much, Mr. Chairman.

I am pleased to testify before you today on HUD's Congregate Housing Services Program. You asked me to talk about HUD's operating experiences with the program and the results of our evaluation of the program.

I would like to point out as I start that there are really three things that we are talking about here. One is the general notion of congregate housing services. Another is the demonstration as it has been conducted; and the third thing is the evaluation. And I think it will become important as I talk about the elements of the demonstration and the evaluation that we keep the distinction separate

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because there are some characteristics of the demonstration and evaluation that may not say a whole lot about congregate housing services as a principle itself.

The Congregate Housing Services Program was authorized as a demonstration under title IV of the Housing and Community Development Amendments of 1978. Under CHSP, HUD provides grants for a core program of meals and minimum support services to selected public housing and section 202 housing projects for elderly, nonelderly handicapped or temporarily disabled who are frail and at risk. Actual services are provided directly by the grantees or by local service providers under contract to the grantees.

CHSP was designed to test four premises: First, that the use of appropriate community-based supportive services can help frail and handicapped people avoid premature institutionalization; second, that the multiyear funding offered by CHSP would alleviate the need of sponsors to spend inordinate amounts of time looking for funds to keep services going; third, that the required coordination with other agencies would prevent duplication of services and help secure appropriate technical resources; and, fourth, that a continuing reassessment of clients and their needs would result in successful targeting of services to those in need.

The key aspects of the program are that housing projects which applied for CHSP had to demonstrate that CHSP services were needed because services existing in the community were insufficient or inadequate to meet project residents' needs. Participants in the program must receive two onsite meals 7 days a week. Additional nonmedical services such as housekeeping, personal assistance, transportation, escort and social services may also be provided to fill gaps in the project's service delivery system. CHSP services are not supposed to substitute for services already provided, but to be in addition to these services. CHSP is generally not supposed to cover more than 20 percent of the residents in a building in order to maintain an atmosphere of independent living. A volunteer professional assessment committee was created at each project to screen all applicants to determine if they were in need of services and what services they were in need of. And clients must pay at least some fee for all the services received.

Now, currently there are about 1,800 elderly and nonelderly handicapped enrolled in the program. About 1,400 of these are elderly and 400 are nonelderly handicapped. Both groups exhibit multiple frailities. The average age among the elderly participants is about 78 years old. Most are female. The nonelderly handicapped population is mostly male, with an average age of 34 years old. Because the population served is not static, that is, when people are no longer at risk they are no longer eligible to receive CHSP services, approximately 3,000 people have been served by the demonstration since its inception in 1980. In addition, over 1,000 temporarily disabled people have received assistance after hospitalization for sickness or accidents.

The CHSP grantees are a highly diverse group. They include both public housing and section 202 projects, in urban and rural areas and on Indian reservations. They are large, medium and small projects. Some grantees have more services available than

others, but all were able to demonstrate the need for additional services.

Now, in creating this demonstration Congress mandated that HUD conduct an evaluation of it on the basis, for example, of the application requirements in the statute. Congress required that the evaluation examine the types and priorities of basic services proposed to be provided and the relationship of such proposal to the needs and characteristics of the eligible residents of the projects where the services are to be provided; how quickly services will be established following approval of the application; the degree to which local services are adequate for the purpose of assisting eligible project residents to maintain independent living and avoid unnecessary institutionalization; the professional qualifications of the members of the professional assessment committee; and the reasonableness of the fee schedules established for each congregate service.

HUD designed a multiyear evaluation to answer these and other questions. A contract for the evaluation was awarded on a competitive basis to the Department of Social Gerontological Research of the Hebrew Rehabilitation Center for Aged. The total cost of the evaluation was $1.75 million, spread over 4 years. The evaluation was divided into three components, each with a completion date determined by the nature of the component.

The process evaluation component analyzed program startup and initial operation. It also included comparisons of the support services that grantees and similar projects were receiving prior to initiation of the program.

The performance evaluation focused on the use of program services by residents in CHSP buildings. This component looked at the targeting and tailoring of services and the costs of the program. This component also provided descriptive analyses of the demographic and functional characteristics of CHSP participants and information on other Federal programs and funding sources for services similar to CHSP.

The impact evaluation component, which is the one that is currently under review, examined the effects of CHSP on mortality and institutionalization, whether CHSP replaced the services received informally by the residents as well as the effect of CHSP on maintaining within the site the same level of services from other sources. A report on this component is currently under review by HUD and OMB, and we expect to issue it shortly.

Let me summarize the key findings from each of these reports, starting with the recently completed impact evaluation component.

The impact evaluation component relied heavily on the use of control and experimental groups established for the evaluation. A control group was used to determine if the program had any effect on participants or whether these effects would have occurred in the absence of congregate housing services. However, because participants could not be randomly selected, this component may not have produced results which could be generalized to all people who received CHSP. Nevertheless, the findings can be used to get a picture of the program's impact.

The evaluation looked at the impact of the prgram on mortality, institutionalization and on participants quality of life. The program

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had no impact on mortality rates. The results of the program on preventing institutionalization are mixed. For the first 14 months of the program there were no statistically significant differences in rates of institutionalization between the study's experimental and and control groups. After that time, control group members were institutionalized at a higher rate. However, because more than three-fourths of the recipients in CHSP buildings were not vulnerable prior to program implementation, some of the people initially served were not at risk of being institutionalized.

The impact evaluation found that CHSP services did not substitute for formal services received from other sources or for informal services provided by family or friends. With respect to whether other services funded prior to CHSP were continued after the introduction of CHSP, the maintenance of effect analyses, the evaluation concludes that these services were continued. However, because the evaluation did not collect information on the total cost of these services, it could not draw any conclusions about whether the total dollar amount of these services increased or decreased. The evaluation also found that the participants were willing to accept the fee scales developed by the sites.

Finally, it is important to note that there was little difference in the perceptions of the experimental and control groups on improvements in quality of life factors. This is true even though the experimental group was receiving many services. They viewed their quality of life no more positively than did the control group.

From the performance evaluation we learned that CHSP projects did target services to vulnerable, that is, frail residents. There was, however, considerable variation in the targeting performance by individual sites and some did considerably better than others. The proportion of vulnerable serviced by CHSP ranged from 65 percent to 100 percent, while the proportion of nonvulnerable served ranged from 7 percent to 40 percent.

Because the evaluation highlighted the need for refinement in our requirements on targeting, we have made a change in the program. We have modified the program to be targeted more directly to those most at risk. Since June 1983 we have required that those served by CHSP be deficient in two or more activities of daily living, of which one must be eating.

The tailoring analysis sought to answer two questions: First, did the residents who need services receive the services they needed and, second, were services provided to residents who did not need them. The evaluation found that the program was not well tailored to residents' needs. While the majority of residents who needed services at the beginning of the program received them from at least one source, many people who did not need the services were also served. For services related to both meals and chores, 50 percent or more of those receiving such services had no apparent need for them.

The performance evaluation also looked at the costs of the program. For the elderly/handicapped facilities surveyed, the average monthly CHSP cost per participant was $204. Meals accounted for 54 percent of the costs per participant. When the costs of CHSP were compared with the costs of four other long-term care community-based service programs, it was found that CHSP did not cost

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significantly more or less than other similar service programs. However, the evaluation did not perform a cost-benefit analysis of the program, compared to other care programs for the elderly such as nursing home care. Therefore, no conclusions can be drawn about whether CHSP costs less than or is more effective than other programs.

From the process evaluation we learned that the implementation of CHSP was generally successful. As a demonstration CHSP showed that a program of support services can be developed in a timely manner within publicly supported housing; that qualified community professionals are willing to provide assistance on a voluntary basis; and that the provision of services will not have a disruptive effect on building management. CHSP was also instrumental on widening the availability of services at CHSP sites.

In summary, however, the two key questions about the program, is it cost effective and does it prevent premature institutionalization, were not answered by the demonstration and evaluation.

Thank you for the opportunity to present the Department's experiences with the Congregate Housing Services Program. Now that the demonstration is over, it is prudent for us to reflect on both the evaluation results and our program learning experiences. I would be happy to answer any questions you have on implementation of the program or the evaluation.

[The prepared statement of Kenneth J. Beirne follows:]

PREPARED STATEMENT OF KENNETH J. BEIRNE, GENERAL DEPUTY ASSISTANT SECRETARY FOR POLICY DEVELOPMENT AND RESEARCH

Mr. Chairman and members of the committee, I am pleased to testify before you today on HUD's Congregate Housing Services Program [CHSP]. You have asked me to talk about HUD's operating experiences with the program and the results of our evaluation of the program.

The Congregate Housing Services Program was authorized as a demonstration under title IV of the Housing and Community Development Amendments of 1978. Under CHSP, HUD provides grants for a core program of meals and minimum support services to selected public housing and section 202 housing projects for elderly, non-elderly handicapped, or temporarily disabled who are frail and "at risk." Actual services are provided directly by the grantees or by local service providers under contract to the grantees. CHSP was designed to test four premises:

First, that the use of appropriate community-based supportive services can help frail and handicapped people avoid premature institutionalization.

Second, that the multi-year funding offered by CHSP would alleviate the need of sponsors to spend inordinate amounts of time looking for funds to keep services going;

Third, that the required coordination with other agencies would prevent duplication of services and help secure approprate technical resources; and

Fourth, that a continuing reassessment of clients and their needs would result in successful targeting of services to those in need.

The key aspects of the program are:

Housing projects which applied for CHSP had to demonstrate that CHSP services were needed because services existing in the community were insufficient or inadequate to meet project residents' needs.

Participants in the program must receive two on-site meals, seven days a week.

Additional non-medical services such as housekeeping, personal assistance, transportation, escort, and social services may also be provided to fill gaps in the project's service delivery system.

CHSP services are not supposed to substitute for services already provided, but to be in addition to these services.

CHSP is generally not supposed to cover more than 20 percent of the residents in a building in order to maintain an atmosphere of independent living.

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A volunteer Professional Assessment Committee [PAC] was created at each project to screen all applicants to determine if they were in need of services (the targeting concept of the program) and what services they were in need of (the tailoring concept of the program).

Clients must pay at least some fee for all services received.

Congress appropriated $28.1 million between fiscal years 1979 and 1985 for this demonstration. Thirty-two public housing projects operated by Public Housing Agencies [PHA's] and 30 section 202 projects, for a total of 62 sites, were awarded funds for participation in the demonstration. Approximately $27.8 million of HUD funds has been obligated or committed, with about $300,000 remaining in HUD's reserve. In total, about $42.5 million from all other sources has been committed to CHSP grantees. Thirty five percent of this comes from local sources, including local funds and in-kind resources of the grantees and other local providers.

Currently, there are about 1,800 elderly and non-elderly handicapped enrolled in the program. About 1,400 of these are elderly and 400 are non-elderly handicapped. Both groups exhibit multiple frailties. The average age among the elderly participants is about 78 years old. Most are female. The non-elderly handicapped population is mostly male, with an average age of 34 years old. Because the population served is not static, that is when people are no longer "at risk" they are no longer eligible to receive CHSP services, approximately 3,000 people have been served by the demonstration since its inception in 1980. In addition, over 1,000 temporarily disabled people have received assistance after hospitalization for sickness or accidents.

CHSP grantees are a highly diverse group. They include both public housing and section 202 projects, in urban and rural areas and on Indian reservations. They are large, medium, and small projects. Some grantees had more services available than others, but all were able to demonstrate the need for additional services.

In creating this demonstration, Congress mandated that HUD conduct an evaluation of it. On the basis of application requirements in the statute, Congress required that the evaluation examine:

(1) the types and priorities of basic services proposed to be provided, and the relationship of such proposal to the needs and characteristics of the eligible residents of the projects where the services are to be provided;

(2) how quickly services will be established following approval of the application;

(3) the degree to which local services are adequate for the purpose of assisting eligible project residents to maintain independent living and avoid unnecessary institutionalization;

(4) the professional qualifications of the members of the professional assessment committee; and

(5) the reasonableness of fee schedules established for each congregate service.

HUD designed a muli-year evaluation to answer these and other questions. A contract for the evaluation was awarded on a competitive basis to the Department of Social Gerontological Research of the Hebrew Rehabilitation Center for Aged. The total cost of the evaluation was $1.75 million, spread over four years. The evaluation was divided into three components, each with a completion date determined by the nature of the component.

The process evaluation component analyzed program start-up and initial operation. It also included comparisons of the support services that grantees and similar projects were receiving prior to initiation of the program.

The performance evaluation focused on the use of program services by residents in CHSP buildings. This component looked at the targeting and tailoring of services and the costs of the program. This component also provided descriptive analyses of the demographic and functional characteristics of CHSP participants and information on other Federal programs and funding sources for services similar to CHSP.

The impact evaluation component examined the effects of CHSP on mortality and institutionalization; functional health and recipients' quality of life; whether CHSP replaced the services received informally by the residents; as well as the effect of CHSP on maintaining within the site the same level of services from other sources. A report on this component is currently under review by HUD and OMB. We expect to issue it shortly.

Let me summarize the key findings from each of these rpeorts, starting with the recently completed impact evaluation component.

The impact evaluation component relied heavily on the use of control and experimental groups established for the evaluation. A control group was used to determine if the program had any effect on participants or whether these effects would have occurred in the absence of CHSP. However, because participants could not be randomly selected, this component may not have produced results which could be

generalized to all people who received CHSP. Nevertheless, the findings can be used to get a picture of the program's impact.

The evaluation looked at the impact of the program on mortality, institutionalization, and on participants' quality of life. The program had no impact on mortality rates. The results of the program on preventing institutionalization are mixed. For the first 14 months of the program, there were no statistically significant differences in rates of institutionalization between the study's experimental and control groups. After that time, control group members were institutionalized at a higher rate. However, because more than three-fourths of the recipients in CHSP buildings were not vulnerable prior to program implementation (that is, the program was not particularly well-targeted, according to the evaluators), some of the people initially served were not at risk of being institutionalized.

The impact evaluation found that CHSP services did not substitute for formal services received from other sources or for informal services provided by family or friends. With respect to whether other services funded prior to CHSP were continued after the introduction of CHSP (the maintenance of effect analyses), the evaluation concludes that these services were continued. However, because the evaluation did not collect information on the total cost of these services, it could not draw any conclusions about whether the total dollar amount of these services increased or decreased. The evaluation also found that the participants were willing to accept the fee scales developed by the sites.

Finally, it is important to note that there was little difference in the perceptions of the experimental and control groups on improvements in quality of life factors. This is true even though the experimental group was receiving many services. They viewed their quality of life no more positively than did the control group.

From the performance evaluation we learned that CHSP projects did target services to vulnerable (frail) residents. There was, however, considerable variation in the targeting performance by individual sites and some did considerably better than others. The proportion of vulnerable served by CHSP ranged from 65 percent to 100 percent; while the proportion of non-vulnerable served ranged from 7 percent to 40 percent.

Because the evaluation highlighted the need for refinement in our requirements on targeting, we have made a change in the program. We have modified the program to be targeted more directly to those most "at risk." Since June 1983, we have required that those served by CHSP be deficient in two or more Activities of Daily Living (ADLs), of which one must be eating.

The tailoring analysis sought to answer two questions: (1) did residents who need services receive the services they needed, and (2) were services provided to residents who did not need them. The evaluation found that the program was not well tailored to residents' needs. While the majority of residents who needed services at the beginning of the program received them from at least one source, many people who did not need the services were also served. For services related to both meals and chores, 50% or more of those receiving such services had no apparent need for them.

The performance evaluation also looked at the costs of the program. For the elderly/handicapped facilities surveyed, the average monthly CHSP cost per participant was $204. Meals accounted for 54% of the costs per participant. When the costs for CHSP were compared with the costs of four other long-term care community-based service programs, it was found that CHSP did not cost significantly more or less than other similar service programs. However, the evaluation did not perform a cost benefit analysis of the program, compared to other care programs for the elderly, such as nursing home care. Therefore, no conclusions can be drawn about whether CHSP costs less than or is more effective than other programs.

From the process evaluation we learned that the implementation of CHSP was generally successful. As a demonstration, CHSP showed that a program of support services can be developed in a timely manner within publicly supported housing; that qualified community professionals are willing to provide assistance on a voluntary basis; and that the provision of services will not have a disruptive effect on building management. CHSP was also instrumental in widening the availability of services at CHSP sites.

In summary, the two key questions about the program—is it cost effective and does it prevent premature institutionalization—were not answered by the demonstration and evaluation.

Thank you for the opportunity to present the Department's experiences with the Congregate Housing Services Program. Now that the demonstration is over, it is prudent for us to reflect on both the evaluation results, and our program learning

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experiences. I would be happy to answer any questions you have on implementation of the program or the evaluation.

Mr. BONKER. Thank you, Mr. Beirne, for your testimony.

Since Congress ordered this evaluation, can you give us an approximate date when your Department will be submitting the evaluation to the Congress?

Mr. BEIRNE. We would expect at this point approximately a month. It has received a review from OMB, and we are in the process right now of making corrections and preparing them for a final clearance within the Department.

Mr. BONKER. The Department got the evaluation from the consulting firm when?

Mr. BEIRNE. In June, I believe.

Mr. BONKER. June of this year?

Mr. BEIRNE. Yes.

Mr. BONKER. And the Department reviews the evaluation and kicks it over to OMB and they review it and they send it back to you?

Mr. BEIRNE. Well, there was an intervening step. The first review generally is a review conducted for corrections to make sure that the evidence is consistent, to make sure——

Mr. BONKER. Evidence is consistent with what?

Mr. BEIRNE. In other words, that the conclusions—that the evidence supports the conclusions and that they are consistent with each other and things of that sort. Generally the first review——

Mr. BONKER. Not necessarily whether it is consistent with administration policy?

Mr. BEIRNE. Right. Just to make sure that basically the report is internally consistent.

Mr. BONKER. Hold on. Internally consistent?

Mr. BEIRNE. Right.

Mr. BONKER. I mean you may have, as any administration, certain institutional policies or bias policies.

Mr. BEIRNE. Right.

Mr. BONKER. Are you talking about making sure that the evaluation's conclusions are consistent with those biases?

Mr. BEIRNE. No. Generally speaking we cannot correct the conclusions of the research except insofar as they are inconsistent with the actual research itself.

Mr. BONKER. You are looking just at the document to see whether its conclusions are consistent with the evidence that is provided?

Mr. BEIRNE. Right. In other words, frequently, not just in this study but in other studies, the evidence is not presented fully, the conclusions are not—there may be gaps between the evidence and the conclusions that need to be filled out by the contractor; and what we do is we make suggestions back to the contractor for strengthening the arguments, things of that sort. So that is what happened after June. It went back to the contractor for revision and then it was resubmitted and then it was sent over to OMB, I believe in early August.

Mr. BONKER. You will be submitting the evaluation to the appropriate committees of Congress within a month?

Mr. BEIRNE. Approximately, yes.

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Mr. BONKER. Well, I appreciate your testimony in that you have attempted to share with us some of the summaries and conclusions of the evaluation. I have not had a chance to see the evaluation because it has not been released. Strangely enough, these things do circulate and so my staff has seen a copy of the executive summary, and I am informed that what you are providing here in testimony is a little less encouraging or promising with respect to this program than what the evaluation actually provides. Is it a matter of just picking and choosing things that might sound better than other things when you talk about your impression of the evaluation?

Mr. BEIRNE. No. I believe my statement is consistent with what the overall evaluation—actually in the points that are made in the overall evaluation and the evidence that is provided in it. I am aware of some differences between early drafts of the executive summary and the actual report. I do not know which version, however of these summaries you might be dealing with.

Mr. BONKER. You say, "The impact evaluation component examined the effects of CHSP on mortality and institutionalization, functional health," and then you go to the next page to pick up on mortality and institutionalization. "The program had no impact on mortality rates. The results of the program on preventing institutionalization are mixed."

Mr. BEIRNE. Right.

Mr. BONKER. Now, one of the notions behind congregate housing is that by providing meals and other support services that you would maintain greater independence for that senior citizen, thereby precluding early admission to more costly institutionalized care, but you are saying the findings are mixed.

Mr. BEIRNE. Yes. Well, they are mixed for two reasons: One, the early statistics on the program, say in the first 14 months or so, did not indicate any significant difference. In the later history of the program, there was a difference between the institutionalization of the control group and the institutionalization of the elderly within the program itself.

One of the problems, however—and this goes back to some extent to the restraints of the program and one of the limits of the demonstration, the way it was conducted. One of the problems is that the program had a restriction that essentially no more than 20 percent of the residents in a given project were supposed to be in the program. The problem with that is that most of the way the program served people, they were serving people in projects who were mostly independently capable and it was difficult to control the actual recipients.

Now, because of that, the evidence about the recipients—in other words, the evidence drawn just from analyzing the recipients of the program, it is difficult to tell how much you can depend upon it simply because there may have been significant numbers of people within the recipients of the program who were not initially vulnerable. That does not mean that there are not differences, but it is a question of how much you can draw from the differences.

I think some of this has to do with the restraints that were placed on the program. In general from my understanding of the discussions of the department and from some of the things that

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other members of the principal staff have attempted to do, I do not think there is a general problem with the concept of congregate housing services and the idea of coordinating services. We, over the last 4 years in policy development and research, have had a number of demonstrations in which we have specifically tried for services, not especially for the elderly but throughout, to get cooperation between the departments, and the demonstration was originally, apparently was originally supported on the basis of the idea of getting this type of coordination of services accomplished—which it did manage to do.

And because of that, however, and because of restrictions to avoid redundancy when the legislation was passed and so on, it may be that the demonstration tells us less about congregate housing services than we would like to know, in that congregate housing services as a principle means something wider than the demonstration is actually accomplishing.

Mr. BONKER. I think I understand all that, but I am not sure.

Mr. Wortley.

Mr. WORTLEY. Thank you, Mr. Chairman.

Mr. Beirne, I am not trying to give you a hard time, but can you tell me why it is that HUD never manages to get a report done when it is supposed to be done? It does not make any difference if it is for this subcommittee, this committee or any other committee. Are you shorthanded over there or slow writers?

Mr. BONKER. Perpetual review.

Mr. BEIRNE. I think actually the review has been fairly rapid in my experience. The main problem was that a number of the sites did not get geared up in the timeframe that originally had been expected and they lagged by about 6 months. And initially we had planned to have a draft from the contractor last December. Because of the 6-month lag, the contractor was not able to do that and the contractor also had a certain amount of difficulty getting all the evidence and all the reports from the sites. So there was about a 6-month lag in the contractor's initial submission that came in in June and that is basically what happened.

The impact evaluation was expected to be done by September of this year.

Mr. WORTLEY. I understand. In some of the previous testimony we have been told that persons residing in congregate housing sites feel more independent, satisfied with their lives than persons who are institutionalized. Can you comment on that finding? And you said there is no difference between the experiment and control groups.

Mr. BEIRNE. The control group is not institutionalized. That is one thing. In general, because of the nature of the sites that were used, one of the things that is some matter of concern, I guess, is that the control group generally speaking was also at sites which had a relatively high level of services. So what we are talking about is there are no differences in the perception of the quality of life of the control group and the experimental group, but that does not necessarily mean there would not be a difference between the experimental and the institutionalized.

Mr. WORTLEY. You say some sites provided greater amounts of services than other sites.

Mr. BEIRNE. Yes; there was a fairly wide range in the amount of services partly because you are dealing with different types of sites. You are dealing with public housing sites and you are dealing also with 202 section 8 sites, and the level of services provided at all the sites was very dependent upon the local communities, the resources of the organizations and so on.

Mr. WORTLEY. Why would the preliminary evaluation results you received seem to be much more positive results than the results you are now reporting? What accounts for that?

Mr. BEIRNE. I do not want to downplay the positive results from the standpoint of what was originally looked for in the demonstration when it was designed. The demonstration, for the most part, was designed to establish that the congregate housing services program was a workable program, could establish cooperation between the agencies, enforce coordination of services, that it could be handled at the local level without disrupting the operations of local bodies, whether the organizing bodies of the projects or the local communities and so on. And those results and basically the results of the first two reports, the process report and the performance report, were positive from that standpoint.

The question of the measurement of the impact is a different one and, frankly, one of the things that happens with impact, you have to make sure you are asking the right question. And, you know, just from my own reactions, I am not sure that the demonstration was set up to ask all the right questions, partly because of the restraints that were inherent in the program and the 20-percent limitation and so on, partly because in a way I think congregate housing services within the demonstration is fairly narrowly conceived compared to what is actually going on in the community, in communities already. For example, there are a number of examples of projects, some of them as many as 14 and 15 years old, where nonprofit organizations using old 236 and section 8 program housing are providing congregate services, not as part of our program. They are providing a wide body of services, but they are not restricting what they are doing simply to and trying to target it to what are called the frail elderly. They are providing a kind of overall transitional care, not even care really, but an overall living environment for elderly, who either because of preference or minor disabilities, would prefer not to do their own meals and handle some of their own services, ranging all the way up to the stage where people might have to go into nursing homes.

Because of that—and I think it is hard to measure a lot of what happened because the attempt was made to target, but it was made to target in a very difficult way to enforce. So we have problems, for example, that services frequently were provided to people who did not need them, and so it is hard to tell on the basis of a service recipient what the differences are between the service recipients and people who are in the control group of frail elderly.

Mr. WORTLEY. Have you attempted to determine if it was more beneficial to the frail elderly than it was to others?

Mr. BEIRNE. Partly because the need was greater, it would be more beneficial. But it is just a problem of being able—if you are setting up a control group, it is a problem of being able to determine what you are actually able to prove out of it. It is not so

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much that the report is going to be able to say anything bad about congregate housing services. Basically what is happening is the limitations on the evidence are such that at least with certain questions the report is not going to be able to answer them one way or the other.

Mr. WORTLEY. You are just going to have kind of a—this report is not going to make any specific recommendations; you are not going to say we should continue to pursue this with the frail elderly to see if it does help, it serves a cost effective purpose and extends their lives and improves their quality of life?

Mr. BEIRNE. I do not think the report itself will, for one reason because it does not answer the question of cost effectiveness. However, I do believe that it will go into the policy process and force some thought about ways in which services need to be coordinated and provided for the elderly. That is why I wanted—at the very beginning I tried to make a distinction between congregate housing services as a concept and the demonstration.

We are very open to the idea of demonstrations that coordinate services. We have done a number of them under our quality of life initiatives in the Office of Policy Development such as Project Self-Sufficiency which tends to coordinate services for single parent families. We would expect that, once the report is in final form—and in final form means essentially it will enter our policy process, about the same time as it goes to Congress—on the basis of that I would believe that we would, potentially be able to come out with some recommendations in the future; but the report itself, while it might have some—it will have some recommendations, probably relating to the demonstration as it is conducted, but it may not answer general questions about congregate housing services overall.

Mr. WORTLEY. We appreciate your coming here this morning and giving us an inkling as to what the report will contain and we look forward to receiving it. Thank you.

Thank you, Mr. Chairman.

Mr. BONKER. Mr. Schuette.

Mr. SCHUETTE. Thank you, Mr. Chairman.

Mr. Beirne, thank you for coming here this morning and more fully informing us about the soon-to-be published report on CHSP. I am a strong supporter of this, and in my district, Michigan.

And, Mr. Chairman, in the interests of time I will insert a statement for the record to be included in this, but I do have a question and a follow-up of my colleague, Mr. Wortley.

[The prepared statement of Representative Schuette follows:]

PREPARED STATEMENT OF REPRESENTATIVE BILL SCHUETTE

Mr. Chairman, fellow subcommittee members, honored witnesses and guests, I am pleased to participate in this hearing today on congregate housing services for the elderly and handicapped.

I am a strong supporter of the Congregate Housing Services Program. Congregate housing provides meals and supportive services to older and handicapped persons at the community level. It is important to note that this demonstration program emphasizes community-based services rather than institutional care. Congregate housing facilitates independence and reduces the costs of long-term health care. Additionally, the program relieves the overwhelmed Medicaid system by offering home-based, less expensive care to older and handicapped individuals. I thoroughly believe

that we must continue to support this program to ensure independence and avoid premature and unnecessary institutionalization of elderly people.

We are now charged with an evaluation of the Congregate Housing Services Program. Several matters such as cost-effectiveness, scope and management of the program shall be questioned by Congress prior to reauthorization of the program. While it is imperative that these services remain available to needy communities and elderly populations, it is crucial that Congress oversee the use of Federal funds.

Mr. SCHUETTE. Mr. Beirne, two things on costs and cost-benefit analyses. Quoting in the third paragraph, page 9, "When the costs for CHSP were compared with the costs of four other long-term care community-based service programs it was found that CHSP did not cost significantly more or less than other similar service programs."

What are the other four programs that you weighed, assessed?

Mr. BEIRNE. I do not have the list of those right here.

Mr. SCHUETTE. Could you provide that to me and my colleagues and the chairman and the rest of the members of the subcommittee?

Mr. BEIRNE. Sure.

[The following material was subsequently received from Mr. Beirne:]

The four programs used for comparison were: Massachusetts Home Care Program, Medicaid waiver clients served by ACCESS in Rochester, New York; Geriatric Day Care clients in Delaware; and Senior Centers serving the functionally impaired in Delaware:

Program	Average hours of care per day	Cost per month (1982 dollars)
Massachusetts	1.3	175
ACCESS	3.6	158
Geriatric day care	2.4	388
Senior centers	2.2	167
CHSP	1.7	204

Mr. SCHUETTE. Second, considering that same paragraph, page 9, "However, the evaluation did not perform a cost-benefit analysis of the program compared to other care programs for the elderly such as nursing home care," and, therefore, no specific conclusions can be drawn. Mr. Wortley touched on that. Why was a cost-benefit analysis not done?

Mr. BEIRNE. OK.

Mr. SCHUETTE. Nothing critical, but we are curious.

Mr. BEIRNE. We are curious too. The program was designed in the late 1970's and essentially I think, if we go back, the question that was being asked and what they wanted to prove with the demonstration was not cost-benefit oriented, at least initially.

Mr. SCHUETTE. It should have been made so we can have a cost-benefit analysis.

Mr. BEIRNE. The problem was by the time we came in and the staff had started looking at trying to do it, it would have involved having to go back and redo the whole contract all over again for the evaluation, because the cost-benefit would probably have doubled the cost of the evaluation, among other things. In hindsight I would say it probably would have been better to put it in. The

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problem was that that was not the question they were asking at the time.

Part of the history of this—and we have had some experience of it ourselves—part of the history of this is it is very difficult to get the agencies to cooperate on providing services at the local level, and the initiative apparently was an attempt to get that type of coordinated service and in various ways to either allow, encourage and kind of impell the agencies to cooperate in order to provide combined services, yet at the same time not be redundant

And the aim of the demonstration was to prove that that could be done, that it would not be disruptive to the local communities to try to get these services provided and so on, and the emphasis was so much on getting it done that I think the question of cost-benefit simply was not addressed.

Mr. SCHUETTE. If you can provide me with the cost of those four other programs, what the other programs were versus the cost of CHSP, I would appreciate tnat.

Mr. BEIRNE. Sure.

Mr. SCHUETTE. Thank you very much for your time.

Thank you, Mr. Chairman.

Mr. BONKER. Thank you.

I see we have a pending vote. I would like to pose a number of questions to Mr. Beirne, and then I suggest we recess for 10 minutes, and then the other witnesses can find a place at the witness table and we will proceed at approximately 11:05.

Dr. Beirne, I just wanted to ask about two statements in your testimony. On page 8 you make reference to the evaluation of the congregate housing services program in the context that the projects did target services to vulnerable, that is, frail residents. I think that is in the last paragraph. "From the performance evaluation we learned that CHSP projects did target services to vulnerable residents."

On page 7, the previous page, in the third sentence from the bottom, and this is a parenthetical statement, you say, "The program was not particularly well targeted."

I am a little confused. Is the program well targeted or is it not well targeted or is it mixed?

Mr. BEIRNE. The easy answer would be yes. It is not—it was well targeted in the sense that overall most of the benefits went to the frail elderly. The problem—there were two ways in which it was not effectively targeted, and what that did was it affected the level of benefits. Ideally if it were fully targeted, 100 percent of the benefits would go to the frail elderly.

Mr. BONKER. 100 percent? I thought it was 65 to 100 percent.

Mr. BEIRNE. Ideally, in a fully targeted program, all its benefits would go to its target group. The problem was that there were both problems in the performance of the sites in getting the benefits to the targeted group and in enforcing the limitations of the benefits to the target group; and a more basic issue in that the majority of the sites selected for the demonstration turned out to have few truly vulnerable residents. Second, because of the way it was designed, for example, rather than having buildings in which the majority in the building was vulnerable, 80 percent essentially of the building was going to be people who were not targeted members of

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the group, which means you guarantee more costly provision of the services. And this is one of the things—this is one of the reasons, I think, there was a problem with the demonstration.

As I mentioned, in both the private sector and nonprofits that are doing congregate housing services programs they usually—they do not get themselves into the kind of bind where they have to try to make these decisions. They may make the distinctions based on pricing arrangements so people who cannot afford certain things may get subsidies or support to do that, but to try to target at 20 percent of the people within a given building, when the service essentially is going to be provided to the whole building, may increase program costs.

It was targeted in the sense that most of the benefits went to the frail elderly; however, given the nature of the demonstration, it was not as cost effective as it could be.

Mr. BONKER. I gathered from your overall testimony today that the current administration position is one of neutrality on congregate housing. Do I infer from that you moved from a position of hostility to one of neutrality on the program?

Mr. BEIRNE. Well, I have not been able to find any evidence in HUD of any hostility to it. I would say it is a neutrality. I think the concept, the idea of the coordinated services being provided for the elderly in general and the frail elderly in particular, is one that we would generally support. I think it comes down to a question of exactly how you go about that.

One of the things we would probably want to explore was the extent to which the resources already exist for doing that. However, there are regulatory, insurance program or other restrictions which prevent the local governments and the local agencies from being able to effectively coordinate these resources and, you know, from that respect it might well be we could accomplish similar things that the Congregate Housing Services Program does if there were a greater coordination required or allowed at the local level between the programs which were already available.

My point is, if I might—I was speaking to someone at basically a congregate housing services facility which is not part of the program in Ohio, and he pointed out that they have in the past, since a large number of the people in the facility would qualify for food stamps, they have in the past had the availability of the commodity products from the Department of Agriculture. However, recently because they are technically not eligible to accept food stamps they also have been told they can no longer participate in the Commodity Products Program. Essentially, to some extent, what you have is a situation there in which a resource which would normally be available to the residents of the project is not available because of basically a failure of coordination among agencies.

In HUD, the way our insurance program operates, congregate housing facilities, generally speaking, new ones are required to build in kitchens, full kitchens in the units.

Mr. BONKER. Why?

Mr. BEIRNE. The insurance——

Mr. BONKER. If you have congregate housing, why do you need a kitchen?

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Mr. BEIRNE. I just asked myself that recently, because we have been looking at the potential designs for more affordable housing, and apparently a part of it is a concern in the insurance programs about the marketability of projects if they should default or something.

Mr. BONKER. I would think the insurance programs would be more concerned about having kitchens. I mean a benefit, if I were an insurance broker, would be not having the kitchens because that is probably where fires usually start.

Mr. BEIRNE. But this is the mortgage insurance. It is concerned with defaulting, and what they are concerned about is the potential value, for example, on resale if the project were to default.

However, what happens is that adds in costs.

Mr. BONKER. I am sure it does.

Well, Mr. Beirne, when we get this report within a month, are we going to get a copy of the evaluation or are we going to get a report that has been rewritten by the Department?

Mr. BEIRNE. You are going to get a copy of the evaluation. At best, from the comments and stuff I have seen, it will be—there will be some amendments made, but they are generally minor.

Mr. BONKER. Will we know if amendments have been made?

Mr. BEIRNE. Pardon me? You will know? I will find——

Mr. BONKER. My question is, we have got the evaluation which was performed on a contractual basis.

Mr. BEIRNE. Right.

Mr. BONKER. That evaluation has been making its rounds——

Mr. BEIRNE. Right.

Mr. BONKER [continuing]. In the executive branch. My question is, when we get the final product, will it be that evaluation that was submitted to you for review or will it be a report that is written by the Department with that evaluation in mind?

Mr. BEIRNE. No. You will get the evaluation written by the contractor.

Mr. BONKER. OK.

Mr. BEIRNE. With corrections that we suggested and so on.

Mr. BONKER. OK.

Mr. BEIRNE. In general our research requirements are that we can make suggestions to the contractor and work with him on things like that, but they are responsible for the report and the conclusions that will be sent to Congress.

Mr. BONKER. We are going to get an authentic evaluation?

Mr. BEIRNE. Right.

Mr. BONKER. Untouched?

Mr. BEIRNE. No, not untouched. Not rewritten, I can guarantee you.

Mr. BONKER. Uncensored?

Mr. BEIRNE. Uncensored.

Mr. BONKER. Mr. Beirne, thank you very much for coming here. We will probably want to submit some additional questions in written form, so we will keep the record open for that purpose.

Thank you once again.

Mr. BEIRNE. Thank you very much, Mr. Chairman.

Mr. BONKER. I would like to call to the witness table then the additional participants and they are Mr. Al Eisenberg, Ms. Elaine

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Anderson, Ms. Anne Gardner, Dr. Powell Lawton and Mr. Wooten Epes.

Please come forward. While the witnesses are coming forward, I would like to state for the record Mr. Hammerschmidt is not here today because he has a conflict with other committee hearings as do others on the committee, but he has submitted a written statement which I will ask unanimous consent at this time to have included in the record.

[The prepared statement of Representative Hammerschmidt follows:]

PREPARED STATEMENT OF REPRESENTATIVE JOHN PAUL HAMMERSCHMIDT

Mr. Chairman, I think that it was an excellent idea to convene this hearing on the Congregate Housing Services Program [CHSP]. In this time of budgetary restraint, it seems especially important to examine a program of demonstrated social benefit and fiscal responsibility such as the CHSP.

Over the years I have been a strong supporter of the CHSP. In 1978 I was an original cosponsor of the Congregate Housing Services Act which began the funding for services to partially impaired older persons residing in section 202 housing. Since 1979, $24 million has been distributed to the 63 nationwide CHSP projects which now serve 1,727 older and/or handicapped persons. Each time that Congress has evaluated the cost-effectiveness of this program, I and many of my colleagues on this committee have risen in support of continued funding. In light of the Federal deficit, few of us here today would disagree with the need for fiscal restraint. However, the program's cost-effectiveness, as measured by lower Medicaid costs, has demonstrated that such programs, in the long run, save the Federal Government money.

Statistics indicate that there are a significant number of people in long-term care facilities who do not need to be there. The Congressional Budget Office has estimated that between ten and twenty percent of skilled nursing home patients are placed at a higher level of care than is necessary. Unfortunately, many older persons are forced to enter nursing homes because they are not able to perform some of the basic tasks of daily living. In most cases, many older persons who are institutionalized could continue to live independently in the community if they received reliable social services assistance. By providing needed services, the CHSP provides these people with an opportunity to live independently, with dignity, and to avoid unnecessary institutionalization.

I recently contacted officials at the Department of Housing and Urban Development [HUD] to obtain a cost comparison between the Federal share for congregate services and skilled nursing home care. The average per person cost to the Federal Government for congregate services, including the HUD subsidy for apartment rental, is approximately $4,600 per year. Total skilled nursing home care cost to the Federal Government for my home State of Arkansas, averages $14,600 per year per person. These numbers indicate that we're looking at a savings of over $10,000 per year per person—per year to the Federal Government under the CHSP program. It's important to note that not only does the CHSP provide an invaluable service to many older persons, it is also cost-effective.

I'm pleased to have the opportunity to introduce a fellow Arkansan, Wocton Epes, who is here today as a witness. In addition to his present position as president of the Arkansas Development Finance Authority, he is also the chairman of the Elderly Housing Committee, National Council of State Housing Agencies, on the board of directors of the Council of Independent Development Bond Insurers, and a member of the Southern Growth Policies Board. I'm glad that Wooton is here today, and know that all of us can benefit from his insights on this important issue.

Mr. Chairman, it's disappointing to all of us interested in the CHSP that the HUD evaluation is still not available. I'm confident that the results will demonstrate that providing supportive services in housing projects will allow people to live independently in the community for longer periods of time and reduce the Federal Medicaid costs. Today's witnesses include persons involved with the day to day operations of the program as well as experts in the field of housing and services for older persons. I look forward to hearing their testimony and thank them for their attendance here today.

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Mr. BONKER. Welcome. We just heard from the administration spokesman, and you have a good sense of our interest in this subject; and I know all of you have prepared statements that you have submitted for the record. You can proceed to summarize your statements, if you will. I would like you to hold your oral statements to 5 or 7 minutes. That allows for time for exchanges if that is possible. We shall now proceed in an order in which it has been laid out in the script that is before me, and that means we begin with Dr. Powell Lawton who is director of research at the Philadelphia Geriatric Center. I am informed Dr. Lawton is a well-known expert on how the physical environment affects the elderly and the environmental needs of older persons, and he has written and published a number of books and articles, including a recent one, I understand, and he also is the president-elect of the Gerontological Society of America. My condolences. Anyone who has to be president of any society is entitled to condolences.

We feel privileged to have you before the committee on a subject of mutual interest. You may proceed.

I might inform the witnesses that that was not a signal for a vote. It was a false alarm, but we may have one in a few minutes. I think we can get through Dr. Lawton's testimony.

STATEMENT OF M. POWELL LAWTON, PH.D., DIRECTOR OF RESEARCH, PHILDELPHIA GERIATRIC CENTER; AND, PRESIDENT-ELECT, GERONTOLOGICAL SOCIETY OF AMERICA

Mr. LAWTON. Mr. Chairman, staff, and participants, it is certainly a pleasure to be here today. I see my role in this panel as being one of talking about the broader context in which our congregate housing services program is embedded. What is important about that context is to recognize the tremendous growth in this segment of our population to which the CHSP is beamed; that is, this is what I would call the semi-independent among our 65 and over. That number is about 5 million people right now, just under 19 percent of all older people.

Mr. BONKER. How would you define a semi-independent older person Dr. Lawton?

Mr. LAWTON. These are people whose daily activity is limited in one or more ways. Daily activities are defined as getting about the apartment, getting about outside in the neighborhood, performing various tasks of self-care. In other words, these are people who need the assistance of another person if they are to have their full ability to carry out daily lives. So we have these data from our National Center for Health Statistics. That number is going to grow. Even by the year 2000 that is going to amount to 8 million people. Thus, we are talking about an overall service group of the kind that we would like to have targeted in the CHSP Program, a group that simply absolutely cannot be served in the traditional way that the planned housing services the independent.

Mr. BONKER. Dr. Lawton, let me understand the terms here correctly. Mr. Beirne made reference to the vulnerable individual. Would you put vulnerable and semi-independent in the same category? Are you talking essentially about the same kind of people?

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Mr. LAWTON. No. The vulnerable, the people that we wish to target within the CHSP Program, are a subset of the people that I am talking about. In other words, many of those people have families to assist them or a spouse in the household and, therefore, they would not be targeted for congregate services. Others have disabilities of the kind that they can overcome in ways other than getting the full set of services that CHSP provides.

So we are talking about a more select group who are vulnerable in this sense. The larger group of 8 million people are not primarily at risk for institutionalization, but they are the group from which the institutionalized will come.

Mr. BONKER. Thank you.

Mr. LAWTON. These people will require some level of support in the community beyond what is normally available to older people. We certainly do not want institutions to be the answer for this group. Demographic data tell us that this vulnerable segment of the old-old—the 75 and overs, or 80 and overs—are the group that is growing most rapidly in our population, so we have a real problem to address ourselves to.

Congregate housing is only one of many of what has been called community-based long-term care services for older people. It is an extremely important segment. At this point we have 1.3 million older people living in federally assisted housing for the elderly and some subsegment of that group has aged in place. That is we have a lot of people already in our federally assisted housing who have grown into this old-old and vulnerable age range, and they constitute one of the primary targets for congregate service. However, future cohorts of the older people who might be served in our assisted housing or in our privately developed housing obviously are another target group that we have got to be concerned about; these cohorts will consist of many more people than the vulnerable who are already in place

Our housing services system has provided congregate services for a long time. The congregate housing with which we are most familiar is not federally assisted. Unfortunately, the nonfederally assisted congregate services is largely not a program for the poor. This is a very unfortunate aspect of our total housing scene. One must be able to pay for services or have a private sponsor with a heavy subsidy to provide the traditional mode of congregate housing.

Mr. BONKER. You are talking about something that would cost in the range of $600 to $800 a month?

Mr. LAWTON. At least. That is very low for a fully congregate living arrangement. Many of the so-called life care communities, in effect, provide congregate services at a much higher cost.

But inasmuch as it looks hopeless for our federal and governmental programs to begin to provide full subsidies on a large scale for traditional congregate housing we cannot hope for much of a solution along these lines. So we move along to the CHSP program.

Although I have served on two professional assessment committees for CHSP demonstration programs, I think that others are going to speak more expertly on this topic. Nonetheless, I can certainly attest that this program has served an extremely good purpose. Although we do not have the full cost-benefit data available, it is unquestionably a far more cost-effective means of providing

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support to the frail than in the traditional congregate housing model. It is the only approach that has hope for the poor.

Now, a third model that I would like to say a word about today, because it is something that my own research has led me to, is the observation that there are congregate services being delivered to many of these 1.3 million older people in federally assisted housing that do not come under the title of a formally organized service like traditional congreate houing or CHSP. My research has referred to what I call a patchwork of services. These services are now being delivered to needy older people in traditional housing by a whole list of community agencies. However, these services are being delivered inefficiently, they overlap and they are poorly coordinated. As Dr. Beirne said, agencies often do not agree among themselves. The fact is however, that for most of the vulnerable segment of the 1.3 million this patchwork of services is all that is there.

The good news about patchwork services is they are probably more highly targeted than any other service we have been able to get. A community agency simply will not go into a housing project and deliver its scarce services unless it has made a determination that the potential individual recipient is in need. Thus, in that way our patchwork is extremely useful. It is inefficient because of the incoordination, the lack of planning that goes into the patchwork.

A major conclusion that I would like to suggest today is that some attention through a Federal subsidy to strengthen the patchwork can extend our ability to deliver these congregate services to more older people than we now can. I want very much to say again that I do not suggest this as a substitute for CHSP. I think CHSP ought to live. But I feel that if we develop the patchwork further at the same time that we try to improve the CHSP, the two are probably going to converge at some point down the line. In other words, if I were commenting on CHSP, I would think further economies probably could be achieved by folding the administration of CHSP into housing management, teaching housing management to perform these functions. CHSP probably could be made more efficient by targeting even more stringently. I think the two model services are within the realm of our society to deliver. The poor, on whom our administration has really walked out, would benefit greatly.

[The prepared statement of Mr. Powell Lawton follows:]

PREPARED STATEMENT OF M. POWELL LAWTON, PH.D., DIRECTOR OF RESEARCH, PHILADELPHIA GERIATRIC CENTER

I shall argue today that congregate services within low-rent housing for older people represents one of the most obvious opportunities to extend the independence of older people and to defer the costs in both dollars and damage go self-respect occasioned by admission to institutions. I shall suggest two routes to such congregate services: Congregate housing in its traditional form and a targeted patchwork of services located in noncongregate housing settings.

In order to develop these arguments it is necessary to review a set of facts about the vulnerable elderly and their housing.

1. The demography of the next several decades and its implications for services to older people and the wellbeing of families is well-known. What concerns us here is that the semi-independent segment of this population is expected to expand in a major way. The 19 percent who represent those at highest risk for deprivation in the community or admission to an institution are characterized by continued residence in their own homes but with limitations on their ability to live without assist-

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ance. That number amounts to more than 5 million people now. In 15 years (2000) that number will be about 8 million.

2. Our present and expected community-based longterm care system will be greatly strained to deliver services for these people in their widely-scattered homes in the community. One way to increase the efficiency of supportive services is to deliver them to people in clusters. This minimizes travel time and lowers unit costs. Congregate housing is one way to achieve such clustering. Congregate housing in its traditional form offers, in addition to shelter, a package of services with meals in a common dining room at its core, complemented by other optional services such as personal care, homemaker, couseling, or outpatient medical and nursing services. The congregate housing service model is planned to serve all or most of the tenants in a multi-unit housing complex. Planned congregate housing has been costly to provide and is most prevalent in high-cost, minimally subsidized housing. Notable exceptions are to be found, however, in some housing sponsored by nonprofit organizations where the entire congregate package can be delivered at a moderate cost, for example, the York House apartments at the Philadelphia Geriatric Center. Virtually no fully congregate housing is available for the poor.

3. Housing built for the fully independent is the usual type of housing that has benefited from federal assistance. At this point, there are about 1.3 million units of low-cost housing designed for older people. Since the present administration has virtually ceased producing new housing units for the poor, this clustered housing is where an originally healthy older population is continuing to age and can be expected to live out its lifetime of community residence. With what quality of life will population move into old-old age?

One outcome is that as health declines their needs will go unserved. If they conceal this fact, as many try to do, they may suffer from increasing isolation, malnutrition, and deprivation of health care, but at least they will achieve the goal of being allowed to maintain their independent living status. Others may come to the attention of management and have their tenure terminated against their wills. Since a disproportionately large number of tenants in federally assisted housing are short on informal social supports, the outcome is very likely to be transfer to an institution. Still others will realistically assess their own needs and regretfully conclude that they have to sacrifice their independent living situation in exchange for the greater security offered by a nursing home.

Is there any alternative to this relinquishing of an independent residence? Two models have been suggested and put into operation. One model is the HUD Congregate Housing Service Program, which others will no doubt describe today in depth. Very briefly, the CHSP purchases a set of supportive services to be received by a small proportion of tenants who are assessed and found to require differing combinations of services whose intent is to forestall institutionalization.

The second model I have referred to as the "patchwork of services" because it represents the delivery of widely varying combinations of services by community agencies in essentially unplanned fashion to tenants whose needs have been made evident to the separate agencies. The good news about the patchwork is that in addition to serving a substantial number of individuals it is the best-targeted of all the programs: Individuals are referred for particular needs to services equipped to meet these needs. The bad news is that the pathwork is inefficient, agencies sometimes compete or duplicate, and there is no guarantee of systematic coverage of all tenants in need.

The Philadelphia Geriatric Center a few years ago studied the phenomenon of aging in place in 5 "middle-aged" federally assisted housing environments (i.e., the housing had been in operation for 12 to 14 years). We found that the originally most healthy and younger tenants were the "survivors." Those who had departed no doubt did so because of declining health. The degree of contemporary need of all current tenants was measured. It is necessary to appreciate the exact meaning of the estimates of unmet need. We found about 17% of our 500 tenants to have one or more unmet needs and 7% to have a major impairment in functioning of a kind that might put them at high risk of institutionalization. These are not high absolute percentages of need, but they designate the presence of a needy minority requiring our attention. Let us be certain to recognize first that this number has been depleted by some unknown percentage of marginally independent people who have already left because services were not available. Let us also recognize that the proportion of those in need has not yet peaked, and can be expected to grow somewhat for another 5 to 10 years. Even so, the maximum number in this risk category will constitute a manageable number of people to whom a higher level of supportive services might be delivered. In short, while a need for services has been documented, it

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is on the average probably not as widespread as the most pessimistic have feared. Our 1 3 million older people are not all about to require nursing care.

The second part of my argument will deal with what we ought to be doing with respect to traditional purpose-built congregate housing, the HUD CHSP model, and the service patchwork.

Traditional congregate housing.—The middle and upper-income nonprofit and commercial sector has led the way in developing models for congregate housing that offer high-quality environments that afford security within a context that is clearly residential rather than institutional. The lack of access by the poor to this kind of housing is very troublesome. While I would certainly applaud any effort to provide lower-cost ways of providing these services across a broader economic range, I would have to conclude realistically that in this day of financial pinch, activity in this arena will probably occur primarily in the nongovernmentally-assisted arena.

CHSP

Again, I don't wish to appear to be trying to be doing justice to the CHSP program by a few inadequate sentences. However, I have served on the Professional Assessment Committees of two demonstration sites in their early years of operation and certainly wish to express as strong support as is possible for the idea of upgrading the ability of independent housing by adding a formal congregate services program. The additional costs are very modest by comparison with purpose-built congregate housing. They could probably be lowered further by folding the administration of the program into housing management and relaxing some demands, such as the one that a need for two congregate meals per day must constitute a minimal qualification for participation.

The service patchwork.—The cost of the service patchwork is spread over many community agencies and thus difficult to calculate. The patchwork is probably in place, however, precisely because agencies find it efficient to serve some of their clients in clustered fashion. The patchwork could function even more efficiently if it were planned and overseen by a team representing both the housing sponsor and some of the community in-home service agencies. A small subsidy for this purpose in each area might save at least an equal amount of money in presently inefficiently-expended resources. A condition of such a subsidy should be the collaboration of the housing and the social-services sectors.

The meals portion of the patchwork may be the most difficult to handle as well as the most expensive component. A major asset is the existence of an OAA Title III hot lunch program within the housing. I would go so far as to suggest that every public housing or Section 8 multi-unit site with such a program already in place ought to receive some assistance in further organizing a more efficient patchwork. Home-delivered meals can supplement the typical five lunches per week offered by the Title III program. These services may also substitute for a group-style congregate meals program if the latter simply cannot be provided. It is probable that other means for establishing the meals portion of the patchwork can be devised and should be supported through demonstration projects.

The critical superiority of the patchwork approach lies in its effective targeting; that is, making sure services go to those in need and are not wasted on those without established need. The targeting proceeds in a first phase by the act of referral, usually by a member of the housing staff in a position to know and observe most tenants. Agencies have their own eligibility standards and are thus likely to evaluate referrals in the manner for which their expertise equips them. For the most part it is the agency's own best interest to limit services to the needy. Such an assessment procedure may be less systematic and more error-prone than the more formal procedures practiced in the CHSP program, but it will also probably be less expensive of professional time.

In conclusion, I suggest planned, federally-assisted housing as one service-delivery group because we know there are needy people there and potential clients are clustered. I don't mean in any way that resources should be removed or diverted from other community-based long-term care endeavors. Similarly, I suggest fortifying and streamlining the patchwork because it is already in place and represents an untapped potential. No more do I mean that CHSP programs or an improved CHSP model should be abandoned. In fact, the patchwork and a permanent CHSP model might well turn out to be one and the same.

I also suggest that other planning and experimentation be done to aid us in the long-term question as to how to use this existing housing stock as a component of the community services package that can help people defer institutionalization. It may be that some such housing environments could be selected within a community

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to specialize in congregate care. We need to know whether it is desirable and, if so, how to achieve the transition from what was built as independent housing to a full-blown congregate housing site, perhaps with even more intensive supportive services than now are provided in most congregate housing.

Mr. BONKER. Thank you, Dr. Lawton. That is really a fine idea, but I am not sure you will find any congressional sponsor for what might be called a patchwork subsidy bill.

We are privileged to have with us today Congressman Vento who, unfortunately, is not a member of this subcommittee but a distinguished member of the full Committee on Aging and who has dropped by to get a sense of what we are discussing today but also to introduce our next witness, who I understand is from the great State of Minnesota, Ms. Anderson.

So, Bruce, proceed.

STATEMENT OF REPRESENTATIVE BRUCE F. VENTO

Mr. VENTO. Thank you, Don, for permitting me the courtesy to stop by this morning and to share a little of the hearing with you and the others, and I thank all the witnesses certainly for coming forth.

The establishment of these records is very important for policy-making in Congress. Serving in the House on the Select Committee on Aging, I know how important this type of hearing is for us and I know that many of the members of this subcommittee serve on both of those subcommittees and, of course, this full committee.

It is a pleasure to see in developing this hearing record that you brought in a distinguished panel of witnesses, especially someone that I have a great deal of respect for and that is Elaine Anderson. Elaine has been the administrator for some time of the congregate housing services program. She has been a good advocate for those programs, and it has grown and I think grown in many directions, not just in size but in the sensitivity to the concerns of clients who are served by it. So it is a tough time in terms of meeting social and human needs, especially with the restrictions and limitations on national funding, but I think that if we can get a clearer picture of what is working and what does not, we will more effectively spend the scarce dollars that are available at the national level and, of course, engage local dollars and nonprofit and private dollars in meeting those needs, those needs of the elderly.

So I am pleased to recognize your presence today, Elaine, and I will look forward to your testimony. I have looked over your testimony. I think it is going to be helpful and hopefully we will come back in authorizing measures reflecting on the good thoughts and good work that you are suggesting to us today. So it is a pleasure to have you here. Welcome, and I am positive that these hearings will be useful to all of us.

Thank you, Mr. Chairman.

Mr. BONKER. Ms. Anderson.

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STATEMENT OF ELAINE ANDERSON, ADMINISTRATOR, CONGREGATE HOUSING SERVICES PROGRAM, PUBLIC HOUSING AGENCY, CITY OF ST. PAUL, MN; ON BEHALF OF THE NATIONAL ASSOCIATION OF HOUSING AND REDEVELOPMENT OFFICIALS

Ms. ANDERSON. Thank you for a very nice introduction. I have to come to Washington to see Mr. Vento because we are so busy there doing our programs in St. Paul.

Mr. Chairman, I am Elaine Anderson, the administrator of the congregate housing services at the public housing agency of the city of St. Paul in Minnesota. I am testifying today on behalf of NAHRO, the National Association of Housing and Redevelopment Officials, a 50-year-old association of professionals who administer low-income housing, rehabilitation and community development programs across the country. NAHRO represents over 5,000 individuals and 2,000 independent agencies throughout the country.

I appreciate the opportunity to discuss with the subcommittee NAHRO's views and the St. Paul experience in administration of the congregate housing services program which was authorized in 1978 by Congress. We believe that the confidence that NAHRO has had in this program, the value of it, has been proved by the demonstrations. NAHRO testified in support of the creation of CHSP 8 years ago. We commend the subcommittee for calling these hearings to highlight this experience today.

Mr. Chairman, NAHRO has not had an opportunity to review the final evaluation report on the CHSP demonstrations, which was just summarized by the HUD witness. I would like to comment, however, on one apparent finding as cited by Dr. Beirne, and this is that there is no difference in the quality of life between those receiving CHSP services and those not receiving the services.

Mr. BONKER. Did he make that statement in his testimony, that there is no difference in the quality of life?

Ms. ANDERSON. Yes.

Mr. BONKER. Was he commenting on the evaluation or was that just part of his statement? I cannot recall.

Ms. ANDERSON. It was in his written testimony and then it was stated.

Mr. BONKER. My question is I am wondering whether he was commenting on the evaluation when he made that reference?

Ms. ANDERSON. That was what the evaluation showed, that there is no difference.

Mr. BONKER. I am sorry to interrupt you.

Ms. ANDERSON. This is not consonant with our experience and particularly in our site where we have taken 33 percent of the people in our program from nursing homes and 23 percent from foster homes and hospitals. Then the rest are from public housing.

Mr. BONKER. Speak closer to the mike.

In your program you took 23 percent from nursing homes?

Ms. ANDERSON. Yes, 23 percent of the—no; 33 percent of the people we have served are from nursing homes.

Mr. BONKER. You take them out of nursing homes?

Ms. ANDERSON. Yes.

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Mr. BONKER. So we are spared the enormous costs associated then with nursing home care?

Ms. ANDERSON. That is correct.

Mr. BONKER. He said the evaluation concluded that the CHSP had no benefit with respect to institutionalized care.

Ms. ANDERSON. Our experience in St. Paul disagrees with that strongly.

Mr. BONKER. That is really interesting. So 33 percent of residents came from nursing homes. Where else?

Ms. ANDERSON. Twenty-three percent came from hospitals where they could no longer go back to their homes. They had to sell their homes.

Mr. BONKER. If we are talking about Medicaid or Medicare, why are people retained in hospitals if it is not necessarily acute care? It is very expensive to maintain somebody who might be ambulatory in a hospital. You actually took them out of hospitals.

Ms. ANDERSON. With the DRG's they have to get them out of the hospital very quickly, so at the time we had openings in our program we got calls daily from the hospitals telling us there are certain people who they need to release.

Mr. BONKER. Are these mostly Medicaid people?

Ms. ANDERSON. Yes, low income people who would be on Medicaid.

Mr. VENTO. I think the point is if they were not in the hospital they were in nursing home care or some intermediate facility. They did not go to the nursing facilities, so they still would have received Medicare.

Mr. BONKER. The point is if they are receiving Medicare, they ought to move promptly from the hospital to an extended care facility. That is what the whole program is designed to do, to prevent unnecessary delays in the hospital.

Ms. ANDERSON. Right.

Mr. BONKER. But these might not have been Medicare but mostly Medicaid patients that came out of the hospital.

Ms. ANDERSON. The folks we have worked with are low income with no assets.

Mr. BONKER. So if they are Medicaid recipients they are not necessarily bound by the same Medicare requirements of moving quickly from hospital to extended care to home?

Ms. ANDERSON. Yes. Well, it was a short—because we had vacancies, they were able to use our resource rather than put them in nursing homes.

Mr. BONKER. That is 33 percent and 23 percent, and the remaining?

Ms. ANDERSON. The remaining have come from the Ravoux highrise, from the highrise where we had our site and from a couple of other highrises in St. Paul.

Mr. BONKER. Is this in a report?

Ms. ANDERSON. Yes. It is in my testimony.

Mr. BONKER. Would you submit the report to the committee for our records because it certainly does contradict what the administration has portrayed today by way of that evaluation.

Ms. ANDERSON. Absolutely.

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Mr. BONKER. It is interesting to have such a contradictory view on a similar program. Thank you.

Ms. ANDERSON. It is frustrating to hear that the study does not reflect what we have seen in the program.

Mr. BONKER. Have you seen the evaluation at all——

Ms. ANDERSON. No.

Mr. BONKER [continuing]. In its uncensored form?

Ms. ANDERSON. Only as much as we have heard in June in a report and then what we have heard this morning.

Once the final evaluation report is out, NAHRO would like to take a look at the findings and file a reaction with the subcommittee.

I would like to say that our public housing agency in St. Paul is very proud to have been selected to administer one of the 62 CHSP's. We are in our fourth year, and we feel we are an answer to the problem that every community faces. It is an alternative to nursing homes for a segment of that nursing home population, people who cannot cook, do housekeeping, bathe, dress, et cetera, but who do not need the expensive and extensive medical supervision of a nursing home.

As you know, we are funded through a combination of HUD funds, fees that participants pay in a sliding fee scale and contributions from our local agencies, that patchwork that Dr. Lawton just talked about.

In Minnesota—Bruce can attest to this—we are critically concerned about long-term care because our State ranks second in the Nation on percent of Medicaid dollars spent on nursing home care. Our costs in Minnesota grew from $95 to $554 million in the last 10 years. With the population doubling at the turn of the century, we all have a concern.

So my purpose today is twofold. I would like to stress the importance of CHSP in that it meets a critical need for the low-income aging population, and I would like to tell you about our CHSP experience in St. Paul.

Mr. Chairman, in chart I in my testimony, it describes how CHSP represents the missing step in the successive processes of life from rearing a family to the emptying of the nest to the retirement and leisure and to the illness and disability. Too frequently there is no alternative in the community for people with declining ability to be assisted other than with nursing home care.

Because the CHSP has now been successfully demonstrated, we would like to see that it becomes a permanent CHSP program for the thousands of low income people in federally assisted housing. It is a most viable alternative to premature institutionalization. The public housing program alone consists of 500,000 elderly households and it is estimated up to 25 percent of those, about 125,000, are vulnerable and at risk. Yet few of these elderly, as I said before, can afford to pay for medical care of a nursing home.

The Government and the States combined have to foot the bill for nursing home care when these people are placed. So we believe that both the Federal and the State governments can derive important social and economic benefits from a CHSP that assists low income elderly.

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The program enables elderly to maintain their independence longer, at far less cost, and for this reason NAHRO urges the subcommittee to consider seriously a permanent CHSP which involves a joint effort by the Federal and the State governments.

We are developing some specific ideas in this regard and would be pleased to make them available to you.

Mr. Chairman, I would like to draw your attention to some background material describing the St. Paul public housing experience, including an important targeting tool, the assessment criteria for independent living skills that is used by our professional assessment committee, also a summary of the characteristics of the CHSP participants, selected case studies, and articles from the Minnesota publications on the CHSP.

Chart No. III attached to the testimony provides a summary of the 44 persons currently participating in our program. Over the three years we have been able to serve 92 people on the program on an ongoing basis and 24 people on a temporary basis while they recuperated from short-term health problems. Some participants are in their fifties and sixties and they are battling cancer, emphysema and paralysis from strokes, but most of the participants are in their eighties and nineties, and I was going to restate that 33 percent of our people we have served have come from nursing homes. So I won't go into that right now.

But I think it is significant and I want to restate that when the people have to leave CHSP they truly need the 24-hour medical skill care of the nursing home. Forty-six percent of the people who have left our program have moved to nursing homes, and these people have had to be on medical assistance.

Mr. BONKER. One would conclude therefore that if there were no CHSP program to serve as an intermediary or an intermediate phase——

Ms. ANDERSON. That is right.

Mr. BONKER. I just cannot understand how this evaluation which cost $1.75 million could conclude otherwise.

Ms. ANDERSON. Those of us who are administering the programs feel likewise.

The average income of our participants is $476. Most of them had less than $3,000 in savings, so you can tell within the first month of moving into a nursing home that they would have to go onto medical assistance.

I would also like to point out in chart No. IV a summary of the occupancy turnover rates and costs compared to nursing home in our St. Paul project. The average daily costs of the HUD CHSP grant per participant over the 3 years of our grant has been $4.93 per day or $1,800 a year per participant. Then when we take all the other subsidies which we would call the patchwork, they equal $7.77 a day or about $2,800 a year. So the total of the two, CHSP and these other subsidies, come to $4,635 per person per year.

Now, compare that to a nursing home cost in Minnesota. Low cost nursing home beds currently begin at $40.30 per day after you consider the amount that each participant contributes of his own income toward that cost. Compare the difference, $4,635 per year per person to $14,709 per person per year, which is a $10,000 difference, approximately one-third of the cost.

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Mr. BONKER. That is another thing that the evaluation seemed to conclude, which is that there was really no cost benefit to CHSP vis-a-vis other programs.

Ms. ANDERSON. I heard. It sounded like that was an afterthought and it did not get into the design of the program, and so it is not fair to say that it is inconclusive that there is not a cost effective demonstration here.

Mr. BONKER. The administration could have saved $1.75 million by just accepting your report.

Ms. ANDERSON. I certainly wish they would pay me that money and take my report.

Cost benefits aside, the greater concern is that the needed nursing home beds will not be used inappropriately—in Minnesota and in many States there is now a moratorium on the development of nursing home beds—and that the frail elderly are able to live in their comfortable surroundings of their own homes which is what they hoped and dreamed for when they initially rented their 202 or public housing apartments. Of special significance is the St. Paul program successfully attracted important additional local services that enhanced the effectiveness of what we have been able to do with our CHSP dollars. It is clear that there is a significant difference between CHSP costs and the costs of nursing home care.

Beyond the St. Paul CHSP cost experience, detailed and refined analyses are now being completed by a number of research institutes on costs of congregate programs, and we recommend that your subcommittee evaluate this data. Any data that I have seen so far has shown a substantial savings in the utilization of congregate housing with support services rather than medical care facilities.

In our community the need for CHSP services is overwelming. For example, since our program has reached its maximum enrollment of 46 people, I have had to turn down an incredible number of old frail applicants who desparately wanted to stay out of nursing homes. Our waiting list consisted of 13 people for over a year when I realized we could no longer accept applications because it was unrealistic that we would be able to have room for them in our programs; and at that time when we were accepting applications, we were receiving phone inquiries of 30 to 40 a day because there is such a need for alternatives in the community.

I believe that this perhaps reflects what is going on in the country, that alternatives are needed and that the program should be expanded to meet the needs of these low income elderly.

In conclusion, NAHRO believes that congregate housing services is one of the best programs that has come out of Washington in a long time. We know the program is doing what it is intended to do, prevent or delay the premature institutionalization of the elderly. Therefore, on behalf of the CHSP participants and the other elderly like them who need this assistance, I would like to ask that you give full support to authorizing a permanent Congregate Housing Services Program; and I would like to thank you for the opportunity to testify before your subcommittee.

Mr. BONKER. Well, thank you for excellent testimony; and if there is no objection, I would like to have all of the accompanying documents to your statement included in the record, and certainly it will be to our benefit to have an alternative analysis of this pro-

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gram to look at. You have provided that to the subcommittee and we are all very grateful.

[The prepared statement of Ms. Anderson follows:]

PREPARED STATEMENT OF ELAINE ANDERSON, ADMINISTRATOR OF THE CONGREGATE HOUSING SERVICES PROGRAM, PUBLIC HOUSING AGENCY, CITY OF ST. PAUL, MN; REPRESENTING THE NATIONAL ASSOCIATION OF HOUSING AND REDEVELOPMENT OFFICIALS

Mr. Chairman, I am Elaine Anderson, Administrator of the Congregate Housing Services Program of the Public Housing Agency of the City of St. Paul, Minnesota. I am testifying today on behalf of the National Association of Housing and Redevelopment Officials (NAHRO), a 50-year-old association of professionals who administer low-income housing, rehabilitation, and community development programs across the country. NAHRO represents over 5,000 individuals and 2,000 local agencies involved in carrying out these programs.

I appreciate the opportunity to discuss with the Subcommittee NAHRO's views and the St. Paul experience in administering the "Congregate Housing Services Program" (CHSP) authorized by the Congress in 1978. NAHRO testified in support of creating the CHSP program eight years ago. We believe our confidence in its value has been proven by the demonstrations carried out over the past five years by 32 local public housing agencies and 30 Section 202 elderly housing sponsors. We commend the Subcommittee for calling these hearings to highlight this experience.

The St. Paul Public Housing Agency is proud to have been selected to administer one of the 62 CHSP demonstrations operating across the country. Our program is in its fourth year at Ravoux Public Housing, 280 Ravoux Street, in St. Paul. The program is an answer to a problem that every community faces in that it provides an alternative to nursing home placement for frail elderly and/or handicapped people who are unable to manage their activities of daily living, such as cooking, housekeeping, bathing, and dressing, but who don't require the more expensive and extensive medical care and supervision provided by a nursing home. The CHSP is funded through a combination of HUD grants, income-based sliding service fees paid by program participants, and contributions from local agencies.

While our program is now into its fourth fiscal year, we are about to celebrate our third anniversary of actual participation by our residents. October 4, 1985 marks the day, three years ago, when meals and housekeeping/personal care services were first provided to our newly-selected participants.

In addition to participating in writing our CHSP grant request and developing the CHSP in St. Paul, I have acted as a coordinator between the other CHSP Administrators in the United States, writing a newsletter and facilitating an exchange of information for the past one and one-half years. In June, 1984, I cooperated with others in developing a survey of CHSP costs compared to nursing home costs. In June of this year, I helped develop a national workshop, cosponsored by NAHRO, in Washington, DC for those interested in CHSP and long-term care alternatives. So, CHSP has been an important part of my life in the past several years.

We in Minnesota are critically concerned about the long-term care crisis, and for good reason: Our state ranked second nationally in the percent of Medicaid dollars being spent on nursing home care. The expenditures grew from $95 million to $554 million between 1973 and 1983. Our Citizens League and our Metropolitan Council conducted studies and organized task forces last year to examine the problems; several excerpts from their findings are attached to this testimony (Chart V-d).

My purpose today is two-fold. First, I would like to stress the importance of CHSP in meeting a critical need for our aging population, particularly low-income frail elderly persons residing in federally-assisted low-income housing, who are "at risk" of losing their independence and going prematurely to the institutional care of nursing homes. Second, I would like to describe some specific elements of the St. Paul Public Housing experience.

CHSP AS A "MISSING" RESOURCE

Mr. Chairman, congregate housing services represent a currently missing step in the successive processes of life experience, from the rearing of a family to the emptying of the nest, retirement and leisure, illness and disability. Too often, at the present time, there is no effective alternative way that a person with declining ability to be fully independent can be assisted, other than placement in a medical care institution. Chart No. 1 attached to my testimony describes this process and this missing step. The current "in-home" services programs are simply inadequate to

meet the requirements for "on-site" direct services on an as-needed basis. The CHSP demonstration has enabled development of services all under one roof that are for many indispensable to continued occupancy in their apartments. Several advantages to the concept of providing services offered and supervised within the residents' housing development are evident to staff, participants, and families. The most common method of service provision in the local community is, of course, service provided by various "in-home" service vendors.

With these two modes of service administration operating concurrently in our hi-rise development, the efficiency and reliability of these two forms of service delivery can be compared. Our experience shows the following:

1. CHSP on-site staff is immediately aware of participants' condition, changes, and needs, while off-site service managers are unable to effectively monitor these factors.

2. CHSP on-site service is able to meet timely needs. In CHSP, clients can receive 15 minutes of assistance each morning and 15 minutes each evening, or virtually any combination of assistance they need, depending on their health circumstances. On-site service provides for flexibility to meet specific needs and is very cost-effective. On the other hand, off-site service must be provided in large chunks of time—sometimes scheduled at a time of day when the service is needed least. Vendors will rarely send a worker out for less than a two to four hour stretch. Therefore, a client may receive an excess of service at one time of the week or day, and no service when the help is really needed.

3. Participants serviced by CHSP never go without critically needed help. If one CHSP staff person is sick or on vacation, another is on duty to fill participant needs. Frequent complaints are heard about off-site vendors where workers will occasionally not show up, and without warning. The outside vendor/manager is frequently unaware of a worker's failure, so no one is sent to replace the absent worker, and the client goes without the needed assistance.

I am prepared to cite specific cases of how the "on-site" CHSP program provides quicker, more efficient service than "off-site" vendors.

Our experience with CHSP over the past four years shows that a package of well-designed, non-medical supportive services made available to frail elderly and handicapped persons in public housing helps sustain independent living, and prevents premature institutionalization. Further, CHSP services can be provided at far less cost than nursing home care.

Beyond the CHSP demonstrations which are now coming to a close, the availability of an on-going CHSP services program for frail elderly and handicapped persons in federally-assisted housing would be a major contribution toward providing such an alternative for thousands of low-income persons. The federally-assisted public housing program alone is occupied by over 500,000 elderly householders; it is estimated that up to 25 percent—about 125,000 households—may be "vulnerable" and "at risk" of institutionalization. Yet, few of these households can afford the cost of a medical care facility; they would have to rely on "Medicaid support" from federal and state governments. We believe that both federal and state governments can derive important social and financial benefits from a CHSP program that assists low-income frail elderly and handicapped persons in government-assisted housing. Such households can maintain independence longer, in a more normal living environment, and at far less cost to the government than placement in institutions. Only a modest amount of renovation of existing federally-assisted public housing developments would be necessary, largely to accommodate a meal service facility; this should be an eligible cost under the Public Housing Modernization program. For these reasons, NAHRO urges the Subcommittee to consider seriously a permanent program of congregate housing services in assisted housing which involves a joint effort by federal and state governments. We are developing some specific ideas in this regard, and would be pleased to make them available to you.

THE ST. PAUL EXPERIENCE

Mr. Chairman, I have attached to my testimony some background material describing the St. Paul Public Housing experience including the assessment criteria for "Independent Living Skills," a summary of the characteristics of the CHSP participants, selected case studies, and articles from Minnesota publications.

The first step in a local CHSP involves identifying the needs of vulnerable persons who require support services with the assistance of a volunteeer Professional Assessment Committee (PAC). The assessment criteria for "Independent Living Skills" used in St. Paul are attached as Chart II. Using these criteria, a person's skill level and resulting suitability for assisted housing occupancy, as well as an appropriate

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cluster of support services, are determined. In our program, a pattern of frailities includes weakness, confusion, forgetfulness, poor judgment, depression, inability to handle finances, change or stress. Many persons are unable to cook, clean, launder, ship, or make and get to doctor appointments. They need help, but under current circumstances, public housing manages are required to terminate the leases of older people who start to manifest the above problems because there are no available support services to enable them to continue to live independently. I have had the heartbreaking task, before CHSP services became available, of turning away from public housing frail elderly who were making every last effort to avoid institutionalization.

Chart III attached to this testimony provides a summary of 44 persons currently participating in the St. Paul program. Over the three years, we have been able to serve 92 persons on an on-going basis and 24 on a temporary basis while they recuperated from a short-term health problem. Some participants are in their 50s and 60s, battling cancer, emphysema, and paralysis from strokes. But most participants are in their 80s and 90s. Significantly, 33 percent of those currently being served came directly from nursing homes. An additional 23 percent came from hospitals, private residences they could no longer maintain, or foster or family situations that were not working out. The balance came from aging occupants of our public housing developments. Significantly, also, 46 percent of those leaving the CHSP program went directly into nursing homes. The average income of this latter group was $476 per month ($5,712 per year); undoubtedly most required federal or state assistance (probably Medicaid) to meet nursing home costs. A full summary of the occupancy and costs of the St. Paul program is attached (Chart IV).

Finally, Mr. Chairman, I would like to summarize our CHSP cost experience.

CHSP—ST. PAUL, MN—SUMMARY OF CHSP 3-YEAR LIFE OF GRANT

Year	Participants	CHSP grant dollars
1982	40	51,132 16
1983	46	76,898 00
1984	46	76,515 00
Total	[1]44	204,545 00

[1] Average.

The average daily cost of the HUD CHSP Grant per participant over the three years of the grant has been $4.93, or $1,800 per year.

The cost of all other subsidies, including local, state, and federal contributions, equals $7.77 per day or $2,836 per year. The total cost of the HUD grant and other subsidies is $4,635. Low cost nursing home beds in this area currently begin at $40.30 per day after patient contributes his income toward the cost ($55.00/day minus $14.70, average patient's daily income contribution). The total annual cost of nursing home care after patient contributions is $14,709.

Assuming that 40 percent of CHSP participants in St. Paul would have required skilled care during the life of the grant, or 18.4 participants at an average cost of $40.30 per day, the cost would have been upwards to $745.55 per day as opposed to $234 per day for those same 40 percent of very frail elderly in the CHSP. CHSP's cost is one-third of the cost of nursing home care.

Cost benefits aside, the greater concern is that needed skilled nursing beds be used appropriately, and, further, that the very frail elderly have the option of living out their lives in the comfortable surroundings of several years of independent living in safe, decent housing for which they opted when initially renting in the Section 202 and/or low-income public housing for the elderly.

Of special significance is that our St. Paul CHSP has been succcessful in attracting additional local services that enhance the effectiveness of our program. The following services have been initiated since CHSP's inception in 1982:

1. The Congregate Dining Program provides CHSP participants with $21,000 per year in subsidized weekday noon meals.

2. The Senior Aide Program has provided two staff people to assist the CHSP with responsibilities. These services are worth $5,200 per year.

3. Ramsey County Nursing Services provides $5,000 in nursing services annually by staffing a weekly nurses clinic in the public housing development.

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4. The Amherst Wilder Foundation added an Adult Day Health Care Program to Ravoux Public Housing, to assist the frail, sometimes lonely and depressed participants in our program. Their contribution to our program is $20,000 per year.

The total contributions from these four sources is $51,200.

It is clear that there is a significant difference between CHSP costs and the cost of nursing home care. Beyond the St. Paul CHSP cost experience, detailed and refined analyses are now being completed by a number of research institutions. We recommend an evaluation of these studies by the Subcommittee. Any data that I have seen shows a substantial saving in utilizing congregate housing, with support services rather than long-term care facilities.

NEED FOR A PERMANENT PROGRAM

In conclusion, we in the St. Paul Public Housing Agency are proud to be a part of this exciting program. We have seen with our own eyes how CHSP truly bridges the gap between independent living and nursing homes. It is NAHRO's hope that the federal and state governments will cooperate in authorizing a permanent program for elderly and handicapped support services in assisted housing—especially based on an effective program—the CHSP!

The need for CHSP services is overwhelming. The demand for specialized services will inevitably increase—not decrease—in future years. My experience with the CHSP in St. Paul has shown that the community really needs additional CHSP programs. Since our program has reached its maximum enrollment (46 participants), I have had to turn down an incredible number of old, frail people who desperately wanted to stay out of nursing homes. Our waiting list consisted of 13 people for over a year when I realized that we could no longer accept applications because it was unrealistic that our CHSP could every have room for them. At the time we were taking applications, I received between 30 and 40 phone inquiries per day about this alternative program. It is frustrating to turn them away knowing that viable alternatives do not exist.

We know the elderly population will double in the next century, but the ability of the wage earning segment of the population to support their needs is expected to be cut in half. The age 85-plus group is the fastest growing segment of the older population in the United States. It is this group that we are seeing in our 15-year-old public housing, where we used to house peppy 65-year-olds. These 85-plus people are most vulnerable to physical, mental, and social limitations that lead to the need for care and services. These same people have an average of $476 per month incomes. Most have just over $3,000 in assets, meaning they will become recipients of Medical Assistance within one month of entering nursing homes.

". . . Our concerns as children, as parents, as taxpayers, as responsible citizens and as persons who will one day be aged—are intertwined as we consider the . . . statistics before us." [*85 and Beyond Report*, Minneapolis]

NAHRO believes that the Congregate Housing Services Program is one of the best programs that has come out of Washington in a long time. We know that the program is doing what it was intended to do—prevent or delay the premature or unnecessary institutionalization of frail elderly and handicapped people in assisted housing who are at risk of such nursing home placement. Therefore, on behalf of CHSP participants and other elderly like them who need this assistance, I ask that you give your full support to authorizing a permanent Congregate Housing Services Program for frail elderly and handicapped persons in federally-assisted housing.

Thank you for the opportunity to testify before your Subcommittee.

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ATTACHMENTS

CHART I -- The Missing Step in the Continuum of Life Stages: Congregate Housing Support for Frail Elderly and Handicapped Persons.

CHART II -- Assessment Criteria for Elderly Persons: "Independent Living Skills," St. Paul Public Housing Authority.

CHART III -- Characteristics of Current CHSP Participants, Ravoux Public Housing, St. Paul, Minnesota.

CHART IV -- Occupancy and Costs: CHSP, St. Paul, Minnesota.

CHART V -- Seven Case Studies of CHSP Participants, St. Paul, Minnesota.

CHART VI -- Articles from Minnesota Publications on CHSP:

VI-a "Program Offers Alternatives to Nursing Home." Good Age Newspaper, Minneapolis-St. Paul, March, 1983.

VI-b Article on CHSP: Minnesota Association of Homes for the Aging, August 7, 1985.

VI-c "Home Environment Includes Food, Care." St. Paul Pioneer Press and Dispatch, February 10, 1985.

VI-d "Minnesota Long Term Care," Excerpts from Report of the Metropolitan Council of the Twin Cities.

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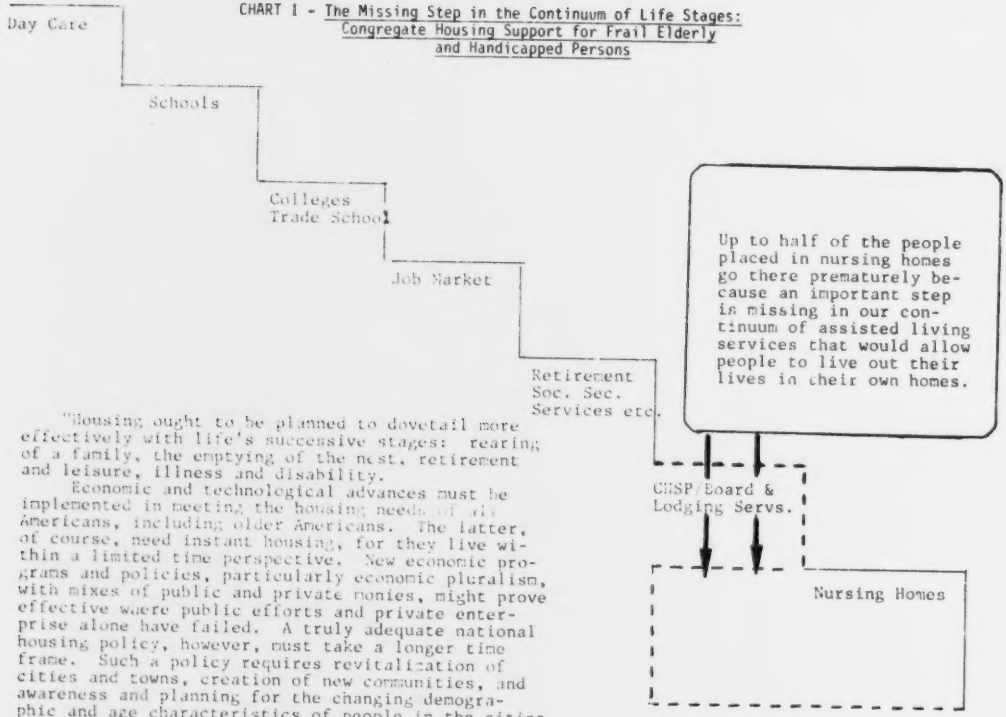
CHART I - The Missing Step in the Continuum of Life Stages:
Congregate Housing Support for Frail Elderly
and Handicapped Persons


Day Care
Schools
Colleges
Trade School
Job Market
Retirement
Soc. Sec.
Services etc.
Up to half of the people placed in nursing homes go there prematurely because an important step is missing in our continuum of assisted living services that would allow people to live out their lives in their own homes.
CHSP/Board &
Lodging Servs.
Nursing Homes

"Housing ought to be planned to dovetail more effectively with life's successive stages: rearing of a family, the emptying of the nest, retirement and leisure, illness and disability.

Economic and technological advances must be implemented in meeting the housing needs of all Americans, including older Americans. The latter, of course, need instant housing, for they live within a limited time perspective. New economic programs and policies, particularly economic pluralism, with mixes of public and private monies, might prove effective where public efforts and private enterprise alone have failed. A truly adequate national housing policy, however, must take a longer time frame. Such a policy requires revitalization of cities and towns, creation of new communities, and awareness and planning for the changing demographic and age characteristics of people in the cities, suburbs and rural areas." Why Survive? Being Old in America
By Robert N. Butler.

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CHART II - Assessment Criteria for Edlerly Persons: "Independent Living Skills"

Independent Living Skills: Elderly

There are 10 "critical" factors which relate directly to lease requirements and immediate health and safety conditions. Should a person's skill level in any of these critical factors fall in the category requiring alternative living situation, management and social service staff should consider this enough to move him to a more suitable living arrangement regardless of ability in other categories.

If a person's skill level falls in 10 or more of the 20 "critical or "contributory" factors within the category of independent with supportive services, a high-rise living situation may not be appropriate. Also, serious consideration should be given to a supervised, service-intensive living arrangement for the person.

It must be emphasized that the 3 categories are viewed as a continuum on which you chart a person's condition, says the agency.

For example, assume a person is functioning mostly in the category of independent with supportive services. As time passes, the guidelines can help management and social services decide if the individual is moving toward the independent category.

	Critical and Contributory Factors	Critical and Contributory Factors Classification → I	II	III*
Critical Factors	1. Meal preparation diet	___	___	___
	2. Housekeeping	___	___	___
	3. Mobility	___	___	___
	4. Personal Care: Toilet	___	___	___
	5. Personal Care: Medications	___	___	___
	6. Time, Place, Person Orientation	___	___	___
	7. Personal Health & Welfare Planning & Decision Making	___	___	___
	8. Presence & Effect of Anxiety, Depression, Phobias, Paranoia	___	___	___
	9. Alcohol/Drugs Uses Abuse	___	___	___
	10. Routine Safety Awareness	___	___	___
Contributory Factors	11. Shopping Capabilities	___	___	___
	12. Financial	___	___	___
	13. Transportation	___	___	___
	14. Personal Care: Bathing	___	___	___
	15. Personal Care: Dressing	___	___	___
	16. Personal Care: Grooming	___	___	___
	17. Personal Habits & Character Traits Relating to Group Living Capabilities	___	___	___
	18. Capability to Maintain Inter-Personal Relationships	___	___	___
	19. Communication Capabilities Hearing, Sight, Speech, Writing	___	___	___
	20. Telephone Communication Capability	___	___	___

*Classification I - Independent
*Classification II - Independent with supportive services
*Classification III - Alternative living situation required

Source: Congregate Housing Services Program, Public Housing Agency, St. Paul, Minnesota, 1984.

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CHART III - Characteristics of Current CHSP Participants
Ravoux Public Housing, St. Paul, Minnesota

September, 1985

AGE	SEX	HEALTH PROBLEMS	START	INCOME	ASSETS	PREV RES
54	M	ARTHRITIS OF SPINE,CEREBELLAR ATAXIA,DEPRESSION, ALCHOLIC	DEC 83	348	0	NURSING HOME
56	F	KIDNEY DISEASE, EPILEPSY,AMPUTEE,DIABETES,DIALYSIS 3X/WK	SEP 84	270	0	FAMILY
58	F	CVA,PARALYSIS,,COLOSTOMY,HERNIA,CANCER OF LUNG,WHEELCHAIR	OCT 82	284	0	RAVOUX
59	M	COPD,CANCER OF ESOPHAGUS,ULCERS, WHEELCHAIR	SEP 84	314	0	NURSING HOME
61	M	COPD,MORBID OBESITY,HEART FAILURE,DIZZINESS,WHEELCHAIR	APR 83	435	0	RAVOUX
66	M	SEVERE EMPHYSEMA,OXYGEN,WHEELCHAIR,CONGESTIVE HEART FAILURE	AUG 83	744	0	NURSING HOME
67	M	DIABETES, DOUBLE AMPUTEE,WHEELCHAIR,RECOVERING ALCHOLIC	OCT 82	438	0	PRIVATE RESIDENCE
67	F	DIABETES,SKIN ULCERS, INFECTIONS, POOR JUDGEMENT	DEC 84	341	0	NURSING HOME
70	F	DIABETES,CVA,PARALYSIS/LFT SIDE, LOWER LEFT LEG AMPUTATED,HBP	APR 83	338	2000	FAMILY
73	F	DIABETES, CONFUSION, DEPRESSION, FREQUENT FALLING	MAR 83	282	0	NURSING HOME
73	M	CVA,WEAKNESS,POOR JUDGMENT,DEPENDENT PERSONALITY	DEC 83	794	2000	FAMILY
74	M	BLIND,DEPRESSION,MALNUTRITION, WEIGHT LOSS	NOV 82	186	0	RAVOUX, HOSPITAL
75	F	EMPHYSEMA, WHEELCHAIR CONFINED	NOV 82	298	0	NURSING HOME
75	F	ARTHRITIS,WHEELCHAIR/WALKER	OCT 82	589	0	NURSING HOME
75	F	COPD,OXYGEN,ARTHRITIS,WALKER	MAR 85	541	0	RAVOUX
75	F	DUO HIP REPLACEMENT, GALL BLADDER SURGERY, WHEELCHAIR	SEP 85	487	0	NURSING HOME/RAVOU
76	M	HBP,DETERIORATED RETINA, GAIT APROXA	APR 83	224	2000	FAMILY
76	M	EMPHYSEMA,FRAIL, HEARING IMPAIRED	OCT 82	685	0	RAVOUX
76	M	PARKINSONS, POOR JUDGMENT	SEP 84	270	3000	FAMILY
77	F	DEGENERATIVE ARTHROSIS,ULCER,ANEMIA,CORONARY ARTERY DISEASE	MAY 83	650	0	FAMILY
78	M	COPD,LEGALLY BLIND,STOMACH MASS, UNDERWEIGHT	OCT 82	447	0	RAVOUX
80	F	BLIND, DIABETES,CHF,WHEELCHAIR	JUN 83	314	0	FAMILY
80	M	CVA,MUTE,CANE,ARTHRITIS IN KNEES,FRAIL	OCT 82	896	3000	FAMILY
80	F	FX.HIP,VERTIGO,DEPRESSION,ANXIETY,CONFUSION,DEPENDENT PERSONALITY	SEP 85	492	0	NURSING HOME
81	F	CVA,WEAKNESS,WALKER,CONFUSION	JAN 83	675	3000	OTHER HI-RISE
81	F	OSTEOPOROSIS,ATHRITIS,WHEELCHAIR	OCT 83	385	2000	PRIVATE RESIDENCE
81	M	HYPERTENSION,DIABETES,CBS	JUL 83	684	3000	RAVOUX
81	F	BLIND, ULCERS, SEVERE DEPRESSION	SEP 85	476	0	RAVOUX/HOSPITAL
82	F	PSORIASIS,OSTEOPOROSIS,HYPERTENSION,EXTREME ANXIOUSNESS,FALLS	APR 83	512	0	NURSING HOME
83	M	CVA,PARALYSIS,WHEELCHAIR,AMPUTEE	MAR 85	593	0	FAMILY
83	M	WEAKNESS,STROKE,WHEELCHAIR	JUN 85	564	0	RAVOUX
84	F	CVA,PARALYSIS,INCONTINENCE,WALKER	APR 84	317	0	RAVOUX
84	F	DIABETES, BROKEN ANKLE,CONFUSION,WEAKNESS	DEC 83	1158	7000	NURSING HOME
85	F	CONFUSION, DIABETES,DIFFICULT BEHAVIOR	JUL 83	545	0	RAVOUX
85	M	PARKINSONS,PAGETS,CHF	APR 84	334	0	FOSTER HOME
85	F	PARKINSONS,LEGALLY BLIND,RHEUMATOID ARTHRITIS,WHEELCHAIR	NOV 83	520	0	RAVOUX
85	F	ARTHRITIS,ANEMIA,HBP,WHEELCHAIR/CANE	NOV 82	270	0	NURSING HOME
86	F	WHEELCHAIR, FRAIL, DIABETIC, MALNUTRITION. CONFUSED	JUN 85	481	0	RAVOUX
87	F	FRAIL,HBP,ARTHRITIS,WALKER	FEB 85	488	0	RAVOUX
88	F	COPD,USES OXYGEN,FRAIL, HEARING IMPAIRED	SEP 84	545	7000	PRIVATE RESIDENCE
89	F	DEGENERATIVE DISC DISEASE,HEART DISEASE, CBS	MAR 83	383	0	PRIVATE RESIDENCE
91	M	CONFUSED, POOR JUDGEMENT,LEAK,WALKER	SEP 85	348	0	EVICTED/APT
93	F	CHRONIC ASHD,CHRONIC HEART FAILURE,ARTHRITIS,WALKER	MAR 83	443	3000	RAVOUX
95	F	ARTHRITIS, BORDERLINE DIABETES,CANCER HISTORY,DUCT STONE	AUG 83	293	0	RAVOUX

CHART IV - Occupancy and Costs: CHSP,
St. Paul, Minnesota
(Oct. 1982 - Oct. 1985)

Overview: St. Paul's CHSP has been providing CHSP services to participants for 3 years since Oct. 4, 1982.

To date, 92 people have been served on a regular basis, and another 24 on a temporary basis while they recuperated from a short-term health problem.

The 92 regular participants have received services for an average of 15 months.

Total CHSP Budget Dollars used over the past 3 years: $ 204,500

The 92 participants cost the program $ 2,222
divided by 15 months (average stay in program) $ 148/month
divided by 30 days (average daily cost) $ 4.93/day

In addition to CHSP dollars, subsidies for other services used by our participants bring the average daily cost of care up to $ 12.70/day

These subsidies include:

HUD rent subsidy
Public Housing Agency contributions
Title III meals
Title XX and Alternative Care subsidy
Elder Adult Day Health Care Subsidy
OTHERS

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Using data from our 1984 study on nursing home costs (included in appendix) we see that average nursing home costs in the U.S. are $55/day. After patient's income is contributed toward that cost, the taxpayers' cost of nursing home care is $ 40.30/DAY

The daily cost difference between nursing home care and CHSP services is: $ 27.60/ DAY

Or approximately: $ 10,000/year

DATA: CURRENT CHSP PARTICIPANTS

There are 44 participants currently in the program, and they have been receiving services for an average of 20 months.

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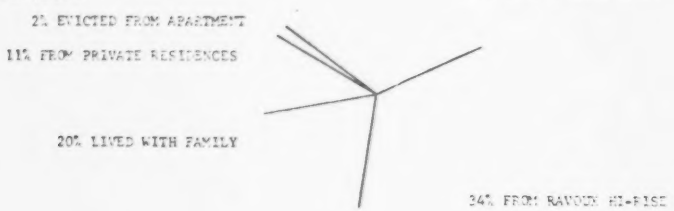

Incomes: The average CHSP participant income is $470 month.

Assets: Average assets are $10[illegible] over the $3000 that participants may retain in their accounts for burial.

Therefore, the average CHSP participant would be able to pay for only 65% of their first month in a nursing home and would then rely on Medical Assistance for all future care.

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DATA ON FORMER CHSP PARTICIPANTS

We have discharged 48 participants from the program. Each received an average of 10.1 months of services before discharge.

Where did participants come from?

46% (22) from nursing homes, hospitals, or received nursing care through foster families or immediate families who could no longer carry the burden and were about to make nursing home placements for their parents.

12% (6) lived in apartments and were about to be evicted due to inability to live independently. These people would have been moved to a nursing care facility.

42% (20) lived in apartments until their health deteriorated and nutrition and housekeeping were suffering.

46% CAME FROM NURSING HOMES, HOSPITALS OR FOSTER ARRANGEMENTS

12% HAD TO MOVE FROM APARTMENTS BECAUSE THEY COULDN'T LIVE INDEPENDENTLY

42% CAME FROM THEIR OWN APARTMENT BUT SUFFERED DETERIORATING HEALTH PROBLEMS

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Discharge information:

46% (22) went into nursing homes.

12% (6) improved and left the program.

42% (20) died.

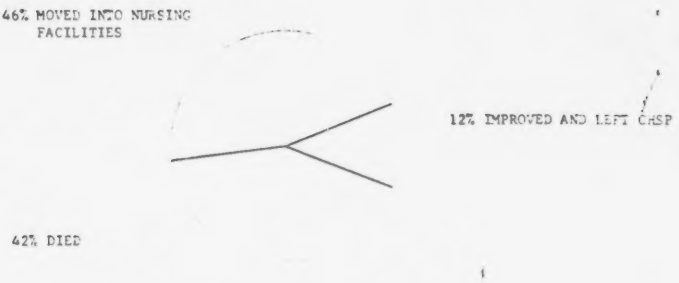

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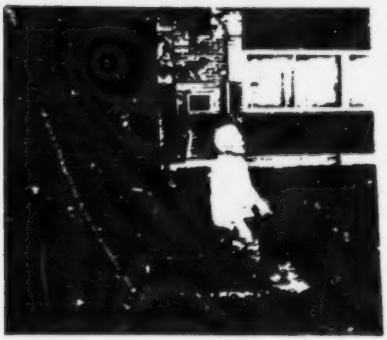
CHART V - Seven Case Studies of CHSP Participants
St. Paul, Minnesota

CASE STUDY



MRS. IQ CHSP SERVICES PROVIDED: MEALS, HOUSEKEEPING, PERSONAL CARE ASSISTANCE

FEMALE: AGE: 94

Mrs. Q had lived at Ravoux for many years when her severe memory loss and confusion began to become evident to everyone. Because her friends remembered her when she had helped so many of the tenants through the years, they were tolerant of her changed and difficult personality. Without the CHSP, Mrs. Q would clearly have been in a nursing home. Instead, she was able to remain in her own apartment until her death.

INCOME: $390 (mo.) SAVINGS/ASSETS: $0

TOTAL NUMBER OF MONTHS IN CHSP: 14 MONTHS COST, INCLUDING ALL SUBSIDIES: $5,334

COST OF NURSING HOME CARE FOR 14 MONTHS: $16,926

TOTAL COST SAVINGS: $11,592

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CASE STUDY

MISS EP CHSP SERVICES PROVIDED: MEALS, HOUSEKEEPING, PERSONAL CARE ASSISTANCE, HOME HEALTH AIDE, NURSE, ADULT DAY HEALTH CARE PROGRAM

FEMALE AGE: 84

Miss EP suffered a stroke several years ago that has left her partially paralyzed on one side of her body, resulting in difficult walking and dependence on a walker. She falls frequently. The stroke also caused some speech problems, and incontinence. Residents have often advised staff that Miss EP should be in a nursing home because of this incontinence. Miss EP continues to live in Ravoux, participating in the CHSP along with frequent services, hanging onto her independence by the skin of her teeth.

INCOME $317 (m). SAVINGS/ASSETS: 0

TOTAL NUMBER OF MONTHS IN CHSP: 18 COST, INCLUDING ALL SUBSIDIES $6,858

COST OF NURSING HOME CARE FOR 18 Months $21,762--

TOTAL COST SAVINGS $14,904

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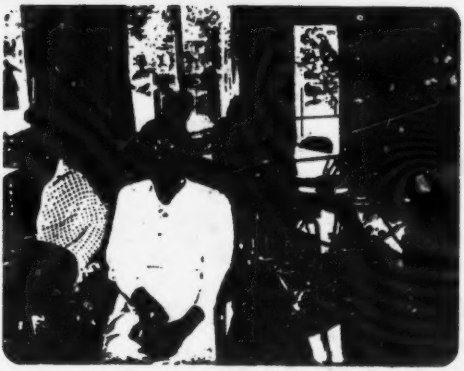
CASE Blow.



MRS. BP CHSP SERVICES PROVIDED: MEALS, HOUSEKEEPING, NURSING SERVICES, HOME HEALTH AIDE, ADULT DAY HEALTH CARE.

FEMALE: AGE 80

Mrs. P lived with her nephew's family in a second-floor apartment until she could no longer climb the stairs. In addition to diabetes, she is blind and has congestive heart failure, stomach ulcers and a mass on her kidney. She is confined to a wheelchair. In spite of her frail condition, she has the energy to demonstrate caring for her friends and family. With the help of staff and family, she is able to remain in her apartment at Ravoux Hi-Rise.

INCOME: $314 (mo). SAVINGS/ASSETS 500

TOTAL NUMBER OF MONTHS IN CHSP: 28 COST, INCLUDING ALL SUBSIDIES $10,668

COST OF NURSING HOME CARE FOR 28 MONTHS $33,852

TOTAL COST SAVINGS $23,184

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CASE STUDY

Mr. KK CHSP SERVICES PROVIDED: MEALS, PERSONAL CARE, HOUSEKEEPING, NURSING VISITS

MALE: Age 83

Mr. K came into the CHSP from a nursing home with the diagnosis of severe diabetes, prostrate cancer in remission and arthritis. He was wheelchair confined. During his second year of participation in the program, he became incontinent and passed out from time to time. Mr. K was readmitted to the nursing home after 24 months with the CHSP. He died several months later.

INCOME $ 360 (ss) ASSETS 0

TOTAL NUMBER OF MONTHS IN CHSP: 24 COST, INCLUDING ALL SUBSIDIES $ 9,144

COST OF NURSING HOME CARE FOR 24 MONTHS $ 29,016

TOTAL COST SAVINGS $ 19,872

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CASE STUDY

MRS O.B. VISITS

FEMALE: AGE 94

Frail, malnourished, confused and depressed, this woman had quit housekeeping and getting dressed. She was falling frequently. Because she had no close relatives to help or visit her, neighbors purchased her groceries, which consisted of tea and doughnuts. The Public Housing Agency would have had to terminate Mrs. B's lease and transferred her to a nursing home because of her inability to meet lease requirements and her unwillingness to accept help. But Mrs. B did finally accept CHSP services after persuasion. She demonstrated that she actually began to enjoy this new lifestyle when she began dying her hair and dressing up in her best dresses and jewelry for dinner each evening. Mrs. B remained with the CHSP for 10 months before she died.

INCOME $340 (mo) ASSETS 1500

TOTAL NUMBER OF MONTHS IN CHSP: 10 COST, INCLUDING SUBSIDIES: $ 3,810

COST OF NURSING HOME CARE FOR 10 MONTHS: $ 12,090

COST SAVINGS $ 8,280

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CASE STUDY

MR. FG CHSP SERVICES PROVIDED: MEALS, HOUSEKEEPING, PERSONAL CARE ASSISTANCE, NURSING VISITS

MALE: AGE: 94

At the age of 93, and weighing 93 pounds, Mr. G needed more care in order to continue living independently. A friend referred him to the CHSP at Ravoux where he lived the next 11 months of his life. During his months in the program, he became increasingly weak. As his ability to get around decreased, Mr. G figured out a way to continue handling his affairs. He made pockets out of miles of string which he tied around chairs pulled close to his easy chair. Into these string pockets he slipped his bills, correspondence and reading materials. Day by day, Mr. G sat, operating quite efficiently out of his makeshift "office" from his red, white and blue-starred easy chair. CHSP staff delivered his meals and took care of his personal care. Mr. G did not like doctors and refused to get a medical evaluation. When he finally agreed to go to the hospital for a check-up, he found that the overwhelming "arthritic" pain he had been experiencing turned out to be cancer. He was then transferred to a cancer home where he lived for two months until his death.

INCOME: $314 (Ss) SAVINGS: 2,000

TOTAL NUMBER OF MONTHS IN CHSP: 11 COST, INCLUDING ALL SUBSIDIES $4,191

COST OF NURSING HOME CARE FOR 11 MONTHS: $13,299

TOTAL COST SAVINGS: $9,106

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CASL STUDY

MRS. Z CHSP SERVICES PROVIDED: MEALS, HOUSEKEEPING, PERSONAL CARE ASSISTANCE, HOME HEALTH AIDE, NURSE

FEMALE: AGE: 78

Mrs. Z suffered from severe emphysema and diabetes. She was wheelchair-confined, and needed oxygen 24 hours a day. She was in and out of the hospital, and frequently CHSP meals were delivered to her because she wasn't well enough to come down to the dining room. CHSP enabled her to live in her own apartment for the last two years of her life, instead of in a nursing home.

INCOME: $520 (HA). SAVINGS/ASSETS: 1,500

TOTAL NUMBER OF MONTHS IN CHSP: 21 MONTHS COST, INCLUDING ALL SUBSIDIES: $8,001

COST OF NURSING HOME CARE FOR 21 MONTHS: $25,389

TOTAL COST SAVINGS: $17,388

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CHART VI-a.

HEALTH

Program offers alternative to nursing home care

By ERUCE STEPHEN

Howard Cullen, a wry seventy-year-old, is recovering from recent heart surgery. He has severe emphysema and carries a small oxygen tank along on his wheelchair to aid his breathing.

Cullen, like many other older people recovering from surgery or impaired by handicaps, cannot provide for all his own meals. Yet, he is not ready for a nursing home. In the past, few alternatives were available to Cullen and other elderly persons who wanted a middle ground between independent living and a nursing home.

Cullen, however, has found the answer to many of his needs through a pilot program unique in the Twin Cities — the Congregate Housing Services Program (CHSP) administered by the St. Paul Public Housing Agency (PHA). CHSP, which was started in the fall of 1982, offers an alternative to premature or unnecessary placement in a nursing home or board and care facility.

Because of the program, Cullen, along with 35 other elderly persons needing special services, now resides in an apartment of the Ravoux High-rise in St. Paul. CHSP's home and one of 15 high-rises for elderly and handicapped persons operated by the PHA.

"The program means that seniors don't lose their independence," said Erik-Paul Sallmen, supervisor of the PHA's human services department which administers the CHSP. "They retain control over their finances, they aren't set apart from their peers and they are able to participate in a normal residential setting."

CHSP, which is funded through a five-year, $460,000 Housing and Urban Development grant, provides participants with all the comforts of home.

Cullen, once an amateur ventriloquist, decorated his new apartment with Charlie McCarthy and W.C. Fields ventriloquist dolls, pictures of his family and a TV for entertainment. On a limited income, he spends $130 per month for drugs to speed his recovery from surgery. That leaves little for rent, food and other expenses.

But, according to Cullen, CHSP's service fee is "pretty reasonable." He and other CHSP participants are required to pay a program fee based on a sliding scale. This service fee is in addition to the 30 percent of a resident's income that goes for rent.

Financing the program through a combination of participants' service fees and the HUD grant has resulted in a considerable savings to taxpayers. In many cases, taxpayers bear up to 95 percent of nursing home costs for low-income people. In the Twin Cities metro area that cost runs between $23,000 and $26,000 annually.

Meals are no longer a problem for Cullen. He cannot cook nutritious meals for himself because of his poor health. And he does not want to subsist on frozen food. CHSP's backbone, a twice-a-day congregate dining program, provides him with well-balanced meals.

In addition to regular meals, participants recently enjoyed home cooked holiday meals at Thanksgiving and Christmas. Melvina Haley, a former restaurant owner and now a CHSP staff member offered her culinary talents.

For Haley and another staff member, Blythe Hanson, solid meals aren't the whole story of their jobs. Both have worked extensively with the elderly for years. Besides housekeeping and food service, the two are interested in discovering the elderly's more hidden needs.

"It's important to know the people, to develop rapport," Haley said. "They need a lot of companionship. Sometimes it means sitting down and having a cup of coffee with them. A good ear is important."

"We try to get to know them and find out what they enjoy," Hanson added.

"CHSP participants are encouraged by the staff to build upon their personal interests.

The backbone of the Congregate Housing Services Program is a twice-a-day dining program that provides participants with well-balanced meals.

Part of our goal is to encourage participants to pick up on things they really like to do," said CHSP administrator Elaine Anderson. "For instance, some of our people have taken trips with Ravoux residents, participated in craft groups, the resident council and played cards."

CHSP packs many services under one roof at Ravoux, which makes the program more workable, according to Anderson.

"All services to our residents either originate at or are coordinated through our office. This makes for more continuity in the services. Our staff, medical and social service providers involved with our people, work cooperatively to give participants the best care possible," Anderson said.

She described the example of one woman who upon entering the program suffered heart failure and then went into a deep depression. Anderson sought outside counseling for the woman's depression and secured an electric wheelchair because the woman's mobility had been seriously impaired by the heart trouble.

Howard Cullen's comments probably best embody CHSP's purpose for the elderly and handicapped.

"I know if I went to a nursing home I would have to share a room and be told what to do. Here I'm still my own boss."

Information about the CHSP can be obtained by calling Elaine Anderson at 298-5130.

GOOD AGE

Good Age is an independent monthly newspaper for the older residents of the Minneapolis-St. Paul area. It is distributed free at over 150 locations, including area businesses, libraries, community centers, senior citizen high-rises and congregate dining sites. Mail subscriptions are $6 per year (12 issues). Two ad rates of Good Age are published — one for the Minneapolis area and one for St. Paul. Circulation for each edition is 11,000 (22,000 combined).

Letters to the editor are welcome. Letters need not be typed but should be signed. Writers' names are withheld on request. Letters may be sent to: Good Age, 777 S. Smith, St. Paul, MN 55107. Editorial and business phone is (612) 227-7998.

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CHART VI-b - Article IV, [illegible] Minnesota Association of Homes for the Aging, [illegible]

Housing News

Published for members of the Minnesota Association of Homes for the Aging

August 7, 1985

CHSP Demonstrates Its Effectiveness

The Congregate Housing Services Program (CHSP), which has three pilot demonstration sites in Minnesota, has proven its effectiveness in helping "at risk" elderly persons avoid premature or unnecessary institutionalization in nursing homes. Evaluations have also shown CHSP to be cost-effective, requiring less public subsidy for services in residential facilities than for nursing home care.

CHSP is a pilot program authorized by Title IV of the 1978 Housing and Community Development Act. HUD was authorized to make grants to selected public housing authorities and 202 projects to provide meals and other services to frail or temporarily disabled elderly and handicapped persons to enable them to live in a residential setting. Under program guidelines, up to 20 percent of the residents in a CHSP facility can participate in the program which includes two daily meals, seven days a week, with at least one daily meal in a congregate setting; housekeeping and personal care services; as well as transportation and counseling as needed. In addition to their rent, participants pay a program fee based on a sliding scale. Federal CHSP funds and local dollars pay the remaining costs, including administrative and case management costs.

Currently, 32 public housing projects and 30 Section 202 projects receive CHSP funding. Three of these demonstrations are in Minnesota: Ravoux High Rise, located in St. Paul, and King Manor and Midtowne Manor II, both in Duluth. The CHSP demonstration at Ravoux High Rise is operated by the St. Paul Housing Authority. The 46 participants receive two daily meals, housekeeping and personal care services funded by CHSP. Other services are also available to Ravoux residents which complement the program, although they are independent of CHSP. The weekly nursing clinic was located here because of CHSP, but is paid for by Ramsey County. The Wilder Adult Day Care program operates at Ravoux three days a week and includes social, recreational and therapeutic activities. Case management is handled by CHSP Administrator Elaine Anderson and her staff in coordination with the county nurses and Wilder staff. Funds for St. Paul's five-year program ran out in April, 1987.

The Duluth Housing and Redevelopment Authority is in the unique position of operating two CHSP demonstrations. Duluth's efforts to assist frail elderly in independent living situations predated the CHSP program. In 1975 a task force was

Minnesota Association of Homes for the Aging, 2221 University Ave. SE, Minneapolis, MN 55414. Gayle Kvenvold, chief operating officer. telephone 612-331-5571

formed consisting of city and county officials and senior citizens. King Manor, the congregate housing facility that developed from this planning process, was first occupied in 1979 and funded under CHSP in 1980. It was the first public housing development in the country to provide Board and Lodging Services in conjunction with other levels of care. King Manor is connected by skyway to a multi-purpose senior center and a 290-unit highrise. Midtowne Manor II, developed in 1982 and funded under CHSP in 1982, also connects by a skywalk to a senior center. Levels of services available at King Manor and Midtowne Manor II are:

- general congregate (one meal daily)
- CHSP (two daily meals, housekeeping, laundry, personal care)
- board and lodging (three daily meals, supervised medication, 24-hour supervision, housekeeping, laundry, personal care and transportation)

Duluth currently has 40 CHSP participants at King Manor and 25 participants at Midtowne Manor II. Thirty-two percent of the participants are over 86 years old. Priority status is given to those on the public housing waiting list in need of CHSP services. The Housing Authority contracts with the St. Louis County Social Services Department to provide CHSP services. A County and Housing Authority social worker evaluate potential applicants and bring the information before a committee for approval of admission. The committee includes a gerontologist, a public health nurse and the housing manager. Following the committee's approval, a resident's care plan is developed and the individual begins the program.

Both Anderson and Virgina Deetz of the Duluth Housing Authority report that the CHSP program has been successful in helping frail elderly avoid premature or unnecessary institutionalization. Both the St. Paul and Duluth programs have had residents move into their programs from nursing homes and hospitals. Nationally, about 11 percent of participants have come from institutions. The Duluth HRA calculates the CHSP daily rate to be $16.07, compared with $25.44 daily for board and lodging; $57.57 for intermediate care and $65.55 for skilled care. Similar cost savings are reflected by a 1984 study of 23 CHSP grantees across the country which showed an average cost of under $5,000 per year per individual for CHSP services and subsidized housing compared to almost $15,000 per year per individual for nursing home care.

A two-year HUD study of 47 CHSP sites is expected to be released soon. Apparently, the findings agree that the program has helped frail elderly avoid early or unnecessary institutionalization in a cost-effective manner. The results of this study may influence the future of the Congregate Housing Services Program, which phases out in 1986. Committees in both the House and Senate have proposed a one-year extension of funding for this program.

It is anticipated that a one-year extension of CHSP will give Congress time to deliberate on the future of CHSP as a permanent program. One suggestion is that states, which now bear about 30 percent of the cost of nursing home care, should be responsible for part of the costs of noninstitutional alternatives through a state/federal matching grant program. The continuation and expansion of the CHSP program is seen as critical by local CHSP administrators. Without it, Duluth estimates that 61 percent of its King Manor participants would need a board and lodging facility and 13 percent would need nursing home care, for an additional annual public cost of $95,743.13.

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CHART VI-c - "Home Environment Includes, Food, Care," St. Paul Pioneer Press and Dispatch, February 10, 1985.

Sally Donachue / Staff Photographer

Occupational therapy assistant Pat Peltzer helps Keep Dorothy Hazelbaka, 80, in tune with life at the Revoux High Rise, thanks to two health-care programs that help elderly and disabled residents.

Home environment includes food, care

By Cynthia Boyd
Staff Writer

Dorothy Hazelbaka used to wander aimlessly in the halls outside her one-bedroom apartment in the Revoux High Rise.

She sometimes didn't eat as she should have. And she didn't take care of herself and her apartment as well as she used to.

"She was a woman of 1 was said," said Dorothy Chesney, directo r of the Wilder Adult Day Care Program at Revoux, a public-housing residence.

Mrs. Hazelbaka's need s wanderings, coupled with her medical background, probably would have sent her to a nursing home a few years ago. But thanks to the Wilder program and another called the Congregate Housing Services Program, Mrs. Hazelbaka and others like her don't have to live in nursing homes. They can stay at their homes in Revoux.

The Congregate Housing Services Program, or the Assisted Living Program as it is also called, provides two meals a day, health care, housekeeping aid, transportation, errand and shopping services.

"We try not to do any more for anybody than they absolutely need" to stay as independent and in control of their lives as possible, said Elaine Anderson, director of the congregate program.

The Wilder program provides social, recreational and therapeutic activities three days a week. It seems to result in happy, rational people. The program opens up new friendships and breaks the monotony of long days, as well.

"Isolation it's depression and isolation as much as physical problems" that lead to problems such as those Mrs. Hazelbaka was having, Chesney said. If people with such problems can take an interest in a group and activities, often their appetites will improve. As they become more active their strength increases. They feel healthier and happier and feel able to take better care of themselves and their apartments. That's what has happened to Mrs. Hazelbaka.

A stroke brought Mrs. Hazelbaka to Revoux. Not unexpectedly, it was hard for this former country school teacher from New Hampton, Kan., to move to the Revoux High Rise two years ago. She had been living in the Redeemer's Arms apartments nearby.

"I liked it there. I liked the people," she said. A pensive look appears on her face when asked why she left Redeemer's Arms. "I got a little diary sometimes," she said.

"You needed a little more help," coached Anderson, director of the program that provides it. "You had a stroke."

"Yes, the little woman with grey hair

Please see Home/4G

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CONGREGATE HOUSING SERVICES PROGRAM
PUBLIC HOUSING AGENCY OF
THE CITY OF SAINT PAUL
280 RAVOUX STREET
SAINT PAUL, MINNESOTA 55103

Home/ Service programs offered only on trial basis

Continued from Page 1G

agreed. She said she needs a walker in case she gets dizzy and loses her balance. "I prayed I wouldn't have to use a walker, but the Lord didn't see fit to spare me that."

After the move, Mrs. Haselbeke was determined. But adult day care and the assisted-living program have given order to her life. She wakes up in the morning to a choice of breakfast in her own apartment or toast and coffee in the community room on the my a floor. At 9:30 a.m. Mondays, Wednesdays and Fridays, she joins the Wilder group for a variety of activities including exercises, a spelling bee, games, crafts, baking, card-playing, parties, health lectures and physical therapy.

There's a break for lunch provided by the Congregate Dining Program. Then, about 1 p.m., the group meets for more activities.

At 3 p.m., the program is over and there is time for Mrs. Haselbeke to return to her apartment to tidy up, read or write letters. A little before 5 p.m., she returns downstairs to the dining room for dinner.

"You eat your supper and then you go back upstairs. I love upstairs, you know. You go back and you think. You go back in your mind," she said.

Often she thinks of her family. She speaks proudly of her daughter and son, seven grandchildren and growing numbers of great-grandchildren. She hears from or sees them often. She recites her daughter Margie's telephone number. "I can call any time," she said.

Her son, Ronald, lives in Kansas, but her daughter-in-law writes long letters regularly.

Mrs. Haselbeke said she's happy. Still, she has her sad moments.

"Sometimes, I wish that no one had to live alone in a place," she said fervently. "Sometimes, I'm ready to cry, but today is different. Today is full of events."

She sat in a small meeting room at Ravoux one January afternoon surrounded by friends, joining in activities led by Pat Peltzer, a certified occupational therapy assistant with the Wilder Adult Day Care Program.

Mrs. Haselbeke's face was as sunny as her disposition. She was having fun helping fill the blanks of a gigantic crossword puzzle hanging on the wall, then clicking bells in rhythm to phonograph music. She was so excited and thrilled by life as a preschooler.

It's a special day, too, because her grandson took her to lunch. "John Michael Pollack's his name. Isn't that a homeland name?" she said.

Photos by Sally Dorscheid / Staff Photographer

Evelyn Peterson, who participates in two programs that help her live comfortably at Ravoux High Rise, is pedaling for her health.

ready to bowl in Bertha Perry, a Ravoux resident who could be in a nursing home rather than in her own apartment, were it not for a trial project at the high rise.

"He was supposed to be studying, but he thought if he took his favorite grandma out for lunch, he'd be in a better mood," she said. "He said he should take me some place special for lunch, but I told him any place is special if I'm with my grandson. That fixed his ego a little."

Fixing eggs is something Mrs. Haselbeke does well, now that she's got a firm hold on life again. She plays a kind of Good Shepherd role, befriending new residents to Ravoux.

"Well, people did that for me," she said, shrugging off Anderson's praise of her kindnesses. "You can stand there pretty lonely if no one comes. Some people are very shy and take a little drawing out."

Anderson recalls the older woman's friendship with a woman named Lida, who was recently moved to a nursing home. "You were a good friend of Lida even though she only spoke Russian," she said to Mrs. Haselbeke. "Remember you tried to teach her English?"

"I tried her," the German woman said quietly. "How is she?"

"Just fine," Anderson answered. "Would you like to go visit her sometime?"

"Yes."

Mrs. Haselbeke probably doesn't know it, but the congregate program and Wilder are offering their services on a trial basis. This is the second year of a five-year grant for the Congregate Housing Services Program, which is subsidized by Title IV of the 1978 Housing and Community Development Act. It is a demonstration project to show that cost considerations in nursing homes can be postponed or avoided if services are provided in the community.

Wilder started providing the day-care component of the program last fall.

The cost of maintaining elderly and handicapped persons in a public housing residence like Ravoux with the congregate housing and Wilder programs (which are subsidized by Title IV funds, the Wilder Foundation and other funds) is one-third of what it would cost federal, state and local governments if the same persons were in nursing homes.

The cost of maintaining elderly and handicapped persons in a public housing residence like Ravoux . . . is one-third of what it would cost federal, state and local governments if the same persons were in nursing homes.

For people like Mrs. Haselbeke, Ravoux is fine. She fears a move to a nursing home. She said her daughter-in-law writes her, "Now, remember, Dorothy, if things get too rough, you can come live with us."

"I, it's kind of mean" to her, she said.

CHART VI-d - Minnesota Long-Term Care: Excerpts from the Report of the Metropolitan Council of the Twin Cities

HOUSING AND SERVICES NEED FOR CONTINUUM OF CARE

Housing is now generally recognized as a key component of the long-term care system. In the past, long-term care was primarily associated with medical and specialized care in institutional settings. However, the increasingly high cost of institutionalization and the physical and psychological benefits the person in need of long-term care generally derives from family and friends have helped focus greater attention on the housing aspect of long-term care.

A continuum of housing types is necessary to meet the range of needs in long-term care. This continuum should range from the most independent setting--the privately owned home--to the most restrictive with the highest level of care--the nursing home or state hospital. (See diagram below.) All those settings are presently available. However, there are problems and issues regarding the need to better adapt some of these settings to the needs of elderly and disabled, their affordability and their availability in all communities where they are needed.

CONTINUUM OF CARE

Residence of Older Person	Older Persons Own Home or Apartment	Subsidized Housing	Congregate or Shared Housing	Board and Care Facility	Nursing Homes
(Independence					Dependence)

The younger elderly, those in the 65-74 year old bracket, show more willingness to move out of their home to a smaller or a more carefree environment. However, given the generally low incomes of the elderly population, current market rate housing being designed for the elderly is affordable only to a small segment of them. For elderly renters, in particular, who as a group have incomes

cosiderably lower than homeowners and have no equity in a home, a move to market-rate congregate housing, for instance, is often out of the question.

Another housing issue involves those elderly individuals who are moderately confused, but in otherwise good physical health. They present a serious burden to their families and are generally placed in a nursing home where their families or the public system then pay for services and care that go beyond what they really require. There appears to be a need for a less restrictive and costly setting for this type of people for whom the main services needed would be those of attendants who would watch for their safety, provide meal preparation and home chore help, but not the service of health professionals.

Excerpt from Long Term Care Study Report.

Conducted by the Metropolitan Council in St. Paul, Minnesota.

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MORE THAN SHELTER

Housing and Services Plan for Older People

NONMEDICAL SUPERVISED HOUSING ("PERSONAL CARE HOMES")

More nonmedical supervised housing should be developed to serve older people who need personal care and supervision, but not the level of nursing care and supervision provided in a nursing home.

The Metropolitan Area has one of the highest rates of institutionalization of older people in the nation. Although there are probably a variety of reasons for this, many think an important factor is the lack of alternative residential settings for older people who are confused some of the time and have some physical disabilities, but do not need medical supervision. These older people have often been placed in nursing homes (particularly intermediate care facilities) simply because there was no other way for them to receive the personal care and 24-hour supervision they needed.

Few residential arrangements providing personal care services and 24 hour nonmedical supervision are available in this Area. This is primarily because there has been no reimbursement mechanism or program to pay for this type of housing, which falls between the traditional housing and health systems. The existing housing types that most closely resemble this kind of residential setting are "board and care" homes, residential hotels, and board and lodging facilities. However, there are few standards to ensure quality in these types of housing.

There is a need for residential arrangements that provide personal care services and 24 hour nonmedical supervision. These living arrangements could be called "personal care homes" because of the emphasis on this type of assistance to the residents.

The need for more nonmedical, supervised housing ("personal care homes") should be met in the following ways:

- Sponsors of high-quality housing and services in each county should be encouraged to develop nonmedical supervised housing as part of "campus arrangements" that include specially planned elderly housing and/or a nursing home. When provided in conjunction with a nursing home, these settings should have separate management and should incorporate design features that ensure a residential, noninstitutional atmosphere.

- Federal Section 8 and 202 funds should be used to develop nonmedical supervised housing to make this alternative more available to older people with low and moderate incomes.

  The use of existing public rental housing in Minneapolis and St. Paul to provide additional nonmedical supervised housing should be explored.

Metropolitan Council of the Twin Cities Area
300 Metro Square Building, 7th and Robert Streets
St. Paul, Minnesota 55101

Publication No. 14-83-064

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CAN WE AFFORD TO TAKE CARE OF OUR ELDERLY?

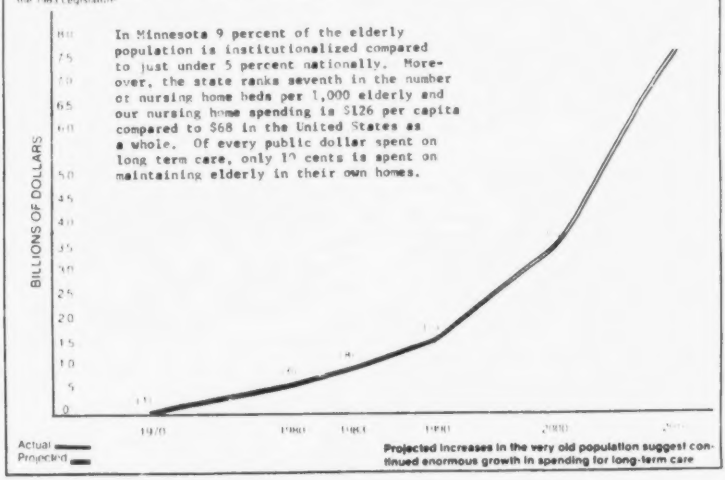
Medicaid expenditures increased nearly five-fold in the period from 1970 to 1980, rising from $110 million to $566 million during the decade and exceeding the rate of inflation by two and one-half times. Nursing home care now consumes two-thirds of the Medicaid budget, and this percentage has generally been increasing. In fact, for years Minnesota ranked second nationally in the percentage of Medicaid going to nursing homes.

Fiscal incentives which favor institutional placement over independent living with supportive services have existed for years in both federal and state policies. In reaction to these incentives, counties have also favored institutional placements over the provision of community services.

Counties pay only 5% of the costs for an individual in a nursing home who is on medical assistance, but must pay approximately 60% of the costs of community services such as homemaker or foster care for an elderly person in the community.

FIGURE 6
Future Minnesota Medicaid Expenditures*

*Assuming constant 1980 institutionalization rates and an annual rate increase of 6 percent per Minnesota Chapter 199, passed by the 1981 Legislature.



In Minnesota 9 percent of the elderly population is institutionalized compared to just under 5 percent nationally. Moreover, the state ranks seventh in the number of nursing home beds per 1,000 elderly and our nursing home spending is $126 per capita compared to $68 in the United States as a whole. Of every public dollar spent on long term care, only 10 cents is spent on maintaining elderly in their own homes.

Projected increases in the very old population suggest continued enormous growth in spending for long-term care

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Mr. BONKER. Now we will proceed to Mr. Eisenberg, and there is no one here to introduce you but myself, I will do the best I can.

Mr. Eisenberg is no stranger on the Hill, having served as the staff director of the Senate Committee on Banking, Housing and Urban Affairs, and I am informed he was one of the original drafters of the congregate housing services program. He retains a great interest in this subject. He is now the director of Government Affairs for the American Institute of Architects, and beyond all that he has had some local experience serving as a member of the County Board of Arlington and involved in the Metropolitan Washington Council.

So you have many hats to wear and a broad base of experience to bring to the subcommittee, and we are very interested to have your testimony, Mr. Eisenberg. Nice to see you on that side of the panel.

Mr. EISENBERG. Nice to be on this side of the panel.

STATEMENT OF ALBERT C. EISENBERG, DIRECTOR, GOVERNMENT AFFAIRS, AMERICAN INSTITUTE OF ARCHITECTS, WASHINGTON, DC

Mr. EISENBERG. Thank you very much, Mr. Chairman, and Mr. Vento and staff.

During my work with the Senate I was one of two persons principally responsible for developing the congregate housing services program in the fall of 1977. We had, at that time, discussions with a wide range of experts in the field of aging and housing. We did a thorough review of the literature at that time, including some earlier congressional hearings which were very revealing, and what we oasically found was what everybody instinctively knew. That is, many people were losing their apartments and were entering institutions because they could not receive the support services they needed to remain at home.

What we found was that services were fragmented, they were diffused, they had conflicting eligibility requirements that met only a portion of a person's needs; and they were inconsistently available from one area to another. The problem was that people were fit to programs when the programs really should have been fit to the people.

There were—I heard about it again today and over the last 8 years I have heard this repeatedly, pledges of cooperation between HUD and HHS. At that time we simply had no faith in those unfulfilled pledges—and those pledges have not been fulfilled to date—to provide the kind of housing we are taking about now.

The annual appropriations process, of course, is another problem. It puts sponsors and tenants in a position of constantly struggling for the next year's dollars. Every 6 months off they go looking for the next dollar to fund the services that are available. We felt the dollar toll and the human toll was just too much, and something had to be done about it.

We decided to give the program to HUD. We viewed it as a housing program, not a services program. Unfortunately, all the people who seem to review this in the administration circles are on the services side rather than the HUD side. When it got up to OMB, at the time we put forth this program, it went to the services people

who did not understand it. It is a housing program. It is a housing option. It gives people a type of living situation that they could not otherwise have.

We recognized there was a whole series of services out there. We wanted to build on what existed. We did not want to replace it. So the CHSP model was a gap filler. It was designed to work with the existing system. In fact, all through the legislation, and all through the legislative history we kept talking about how this program would be prohibited from substituting for any other service that was reasonably affordable and available within a community. We really did not want to get into duplication.

We also put the burden on the local sponsors to come forward with packages of services, that drew from what existed and that filled in with the new congregate housing services to meet specifically the needs of tenants as the sponsors and tenants saw them, and as they saw them with the help of the voluntary professional assessment committee which was a unique concept.

We required that anything that the applicant put together in terms of a service package would have to be sent off to the local agencies responsible for overseeing various kinds of services, Agencies on Aging, those agencies that were responsible for handicapped people. We did that because we did not want to see any duplication and we wanted to make sure that when the provider, the applicant, put together a package of services that he did not miss anything within the community. Then when everybody agreed on the application, it was shipped up to HUD for their review and hopefully ultimate funding.

We wanted the money used quickly. We also provided 3- to 5-year contracts so that people would not have to wonder from one year to the next whether or not their services were going to be intact. This was designed to take a lot of the administrative burden off the people who ran the program, and it would take a lot of worry from the tenants who are the beneficiaries so they would not have to be concerned about the continuation of the program.

We felt it was reasonable to ask people to contribute toward the cost of these services and, of course, a sliding scale of income was the most reasonable thing to do, with different levels of income among the recipients.

We also geared the program—let me rephrase. We designed the program to try to look ahead. We knew that people's conditions would change. We knew that the original application would have to be revised over time to take into account those conditions. We knew that service costs would change, and the availability of services would change. So we built in opportunities to amend the package, to amend the amounts of money going for one service or another.

Let me quickly put on one of my other hats and enter into the present. I am on the County Board of Arlington. We are an affluent community, thankfully. We have the resources to provide a great variety of services to a population of very diverse needs. We have been told we are on the cutting edge of virtually every demographic pattern in the country, and one of them is that we have a rapidly rising number of elderly people.

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But as we have reviewed our service availability, Federal Government, State government, the kinds of services we provide on the local basis, we still find the same problems: lack of coordination, differing eligibility criteria, people falling through the cracks. Now, we have difficulty in placing people in nursing homes in our area. We do not have enough of them. So what happens when somebody needs to go into a nursing home is they go someplace downstate. It is cheaper, but it is also farther away from familiar surroundings, and it is really a burden on them; and if they do not need to be sent to begin with, because a service package that could be available for them would keep them at home, then it takes on some real additional tragedy.

What we have decided to do is, in fact, to take the congregate housing services model and apply it on a local basis. The board approved my proposal to do this in September. We will put together a plan starting with one apartment project and then move ahead from there. We should have something working by the spring, working to keep people in their homes as independent as we can. It will serve people who are above the poverty line; it will serve people who are above the HUD guidelines. Again, we are fortunate we have the money to do that, but we also, as I said, have the same problems in pulling these services together today that you find today all across the country. Personally I think that the coordination feature of this program, the way it can pull things together and intervene effectively based on the experience of people who are actually in the apartments, in the buildings, working with people on a day-to-day basis, I think altogether makes this a model that really should be continued and expanded.

This program makes sense from a government standpoint, and it makes sense from the standpoint of individuals, and it certainly makes sense from the standpoint of cost effectiveness, not to mention the fulfillment of Government's social responsibility.

That would conclude my testimony, and I would be happy to answer any questions you might have.

Mr. BONKER. Thank you, Mr. Eisenberg.

[The prepared statement of Mr. Eisenberg follows:]

PREPARED STATEMENT OF ALBERT C. EISENBERG, DIRECTOR, GOVERNMENT AFFAIRS, AMERICAN INSTITUTE OF ARCHITECTS, WASHINGTON, DC

Mr. Chairman and members of the Subcommittee, my name is Albert C. Eisenberg. I am a Director of Government Affairs for the American Institute of Architects. Previously, I was Majority and then Minority Staff Director for the U.S. Senate Subcommittee on Housing and Urban Affairs. I am also a member of the County Board of Arlington, Virginia.

I appreciate this opportunity to offer some historical perspective on the Congregate Housing Services Act, and want to commend you and your staff for focusing on this means of extending the independence of frail elderly persons.

During my work with the U.S. Senate, I was one of two staff persons principally responsible for developing the Congregate Housing Services program in the fall of 1977. Its principal sponsors were Senators Williams and Church, and it ultimately secured about 35 co-sponsors before its passage as part of the Housing and Community Development Act of 1978.

Discussions with experts on aging and housing, along with a review of the literature, including earlier Congressional hearings, revealed that many people were losing their apartments and entering institutions because they could not receive the support services they needed to remain at home. Services were fragented and diffused, had conflicting eligibility requirements, met only a portion of a person's need,

and were inconsistently available from one area to another. People were fit to programs, when the programs should have fit the people. No one had any faith in the unfulfilled pledges of cooperation between HUD and HHS to provide this kind of housing. The annual appropriations process for service programs left project sponsors and tenants constantly struggling for the next year's dollar to keep sevices intact. Annual funding also precluded development of projects specifically designed for and thus dependent on service availability. No one would finance such projects, if they served people who could not afford services. The dollar and human toll for all this was enormous and we wanted to do something about it.

To end bureauocratic wrangling and inertia, we gave the new program to HUD and put HHS in a secondary role of assisting with regulation development. We viewed the program as a housing program, "housing with help", because the bricks and mortar project combined with services to provide a new housing option.

Rather than create a whole new system, we decided to build on what existed. That made the CHSP model a gap-filler, strictly prohibited from providing services reasonably available within the community. Because service availability varied among areas, we put the burden on the local project sponsor to take full advantage of what existed, and then use CHSP to fill in. In other words, the program would work from the local project up rather than the federal government down.

To determine what combination of local services, and CHSP services would best serve a project's residents, sponsors had to assess tenant needs. We had them set up professional assessment committees which included medical and social work professionals along with the project manager, whose familiarity with the tenants could assist in the assessment. The committee could also track changes in individual tenant needs and conditions.

To save money, we required that committee members serve without pay. Armed with the knowledge of who needed what services, a project sponsor then developed a package of services tailored to the building's at-risk tenants. To prevent substitution of federal funds for local project funds, we required each recipient to maintain at least their current expenditure for services.

We also required that once the application for CHSP funding was complete, before sending it to HUD the applicant had to submit it for review and sign-off to the area agency on aging, and any appropriate groups concerned with the needs of the handicapped. This would assure that no necessary services reasonably available in the community were missing from the application. It also made sure of coordination between the existing programs and CHSP at the local level, prior to submission of the application to HUD.

We wanted the program money used quickly, so we said that recipients had to be using it within 6 months of their award. To relieve the problems caused by annual funding, we provided for three-to-five year contracts between HUD and project sponsors. It was hoped that this improved certainty of funding would encourage development of new, specially designed congregate housing.

Let me mention some other details very briefly. Project sponsors were encouraged to employ non-frail building residents in the delivery of services. We decided to let non-frail building residents receive any of the services they wanted, but we required payment for their cost. At-risk tenants would, however, pay for their services according to a sliding scale of income, to help defray the cost. No at-risk tenant was required to take the services, but we recognized that displacement was the likely consequence of refusal to participate. Finally, we set aside a 10 percent annual reserve at the HUD Secretary level in order to amend contracts over their life due to unexpected changes in the needs of recipients.

Let me change hats and venture into the present. As a local elected official, I have had the opportunity to see federal programs I have worked with unfold on the local level. Arlington County, however, is not eligible for CHSP—it has no public housing and no Section 202's. We do have three Section 8 projects, and a number of unsubsidized projects with large proportions of modest-income elderly. We are an affluent county and take great pride in the full range of services we offer to our elderly. But like other communities, we have experienced great difficulties with the fragmented, uncoordinated nature of federal-state social services. We know people are falling through the cracks. And because of costs and limited bed availability, when they are displaced they often find themselves moved to locations outside of Northern Virginia, away from friends and familiar surroundings, and to institutions that a better social service system could have helped them avoid in the first place.

At our Board meeting on September 21, 1985, the Board agreed to my proposal to plan the implementation of a local CHSP program for Arlington County. We intend to start with a single apartment project, and based on our experience, which I an-

ticipate will be a good one, we will move to expand it for the next fiscal year. The program details should be ready by December of this year.

I think it is appropriate for each level of government—federal, state, and local—to move toward implementing the CHSP model on a broader scale. For both state and federal governments there is great economic incentive to do so because of the cost-savings involved in keeping people in their homes rather than displacing them to nursing homes. Through the kind of federal-state matching program which others will suggest today projects financed or subsidized by either federal or state governments can be assisted, and each would realize a reduction in social service costs as CHSP is applied. Local governments could participate through the federal-state match, or set up their own programs as Arlington County plans to do. It is important for the federal government to maintain an active presence in this effort, for its own economic reward, and for its ability to encourage broader state and local activity. The CHSP has pointed the way toward more efficient social service delivery, and toward new opportunities for independence among our vulnerable citizens. Let's take advantage of the guide we have been provided. I am happy to answer any questions you may have.

Mr. BONKER. We shall now move to Ms. Anne Gardner who is with Health Care Management Associates of Lynnfield, formerly housing specialist with the Bureau of Maine's Elderly. You spent a year in Vermont developing rural congregate housing services programs. You bring to the subcommittee vast experience in this area, and I understand that you are involved now in what Dr. Lawton referred to as the nonfederally assisted congregate housing programs. Is that correct?

Ms. GARDNER. Yes, Mr. Chairman, Health Care Management is involved with developing private housing.

Mr. BONKER. I am pleased to hear from you because my father is presently in that unique category of moving from where he has been living independently in a condominium and he is not quite ready for a nursing home, yet he needs support services. So we sat down and talked about this a few months ago. I said, "Dad, you will either have to move into a facility like this or get married." He figured it all up and he said, "I think the cost-effective way of doing this is to move into this type of housing." So we have been looking at places in my district where he could properly locate, and there are some really fine facilities. So I would be interested in hearing from you today to help me in a personal sense as well as official role as chairman of the subcommittee and also generally what is involved in congregate services beyond just a bed and three meals a day when we talk about support services. Thank you for being here.

STATEMENT OF ANNE M. GARDNER, HEALTH CARE MANAGEMENT ASSOCIATES, INC., LYNNFIELD, MA, AND FORMER HOUSING SPECIALIST, BUREAU OF MAINE'S ELDERLY

Ms. GARDNER. Thank you, Mr. Chairman.

I would like to describe some of the non-Federal approaches to developing Congregate Husing as well as examine some of the barriers to expanding the supply of this form of housing.

Mr. BONKER. Move that mike up so everybody can hear.

Ms. GARDNER. How is that?

I would like to start by describing Maine's Congregate Housing Program. I worked with the Maine program for 6 years as the director of housing for the State office on aging.

In terms of background, in 1980 Maine enacted legislation to set up a demonstration congregate housing program. The State law provided funds for social and health services at two demonstration sites. Funding for the construction and operation of congregate housing facilities had previously been committed by the State office of the Farmers Home Administration for a rural project and the Maine State Housing Authority for an urban site.

In creating the demonstration, Maine was very interested in testing congregate housing as a cost effective and high quality program when compared to the State's boarding and nursing home programs.

Mr. BONKER. Was there an underlying premise that it was an alternative to nursing homes?

Ms. GARDNER. Absolutely. That was part of the test.

Mr. BONKER. This evaluation seemed to conclude that it was not an alternative.

Ms. GARDNER. If I may respond to that, our demonstration results were not at all mixed. They were very impressive. They were very straightforward. We found that in the Congregate Housing Program, 22 percent of the elderly people who moved into the demonstration sites came directly from nursing and boarding homes, the majority from nursing home facilities.

Mr. BONKER. Are we all wrong and they are right?

Ms. GARDNER. We did not spend $1 million plus on our evaluation.

Mr. BONKER. That is the problem. You are not spending enough money on your evaluations.

Ms. GARDNER. Maybe you are spending too much.

I would also urge you and your committee to take a look at other evaluations including a report that was done in Massachusetts a couple years ago. It is called "Congregate Housing: An Effective Alternative." It was funded by HHS and it took a look at Massachusettse Congregate Housing Program. Like Maine, Massachusetts found that in its program 18 percent of congregate housing tenants had been relocated from nursing homes.

Mr. BONKER. Massachusetts?

Ms. GARDNER. Massachusetts.

Mr. BONKER. Wasn't this contract with an outfit in Massachusetts?

Ms. GARDNER. Yes.

Mr. BONKER. The Hebrew Rehabilitation Center for Aged. I have been straigthened out now.

Ms. GARDNER. In terms of costs, what we found in our congregate housing program was an average monthly cost of about $767 compared with an average nursing home cost of $1,300. So, again, both Maine and Massachusetts have had very positive experiences with demonstration programs which then turned into permanent State congregate programs.

Recent 1985 legislation in Maine will triple the supply of the State's congregate housing over the next 2 years. So, the State of Maine has taken a very aggressive approach to increasing the supply of a long-term care program that it views as extremely successful.

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Mr. BONKER. You are talking about a nonfederally assisted program?

Ms. GARDNER. Let me briefly describe how the program works. First of all, in terms of housing, Maine congregate facilities are all federally subsidized complexes which have been developed under HUD or the Farmers Home Administration. We have, by the way, had excellent experience working with Farmers Home in developing rural congregate housing in Maine, Farmers Home or the HUD agency financing the congregate facility monitors the design, development and operation of the housing.

Complementing that housing, the State of Maine provides State funds for the onsite health and social services to make it a Congregate Housing Program. Like the HUD Program, Maine requires professional assessment committees which use standard criteria to select frail elderly for the program. I would like to describe Maine's criteria because the HUD testimony was mixed with regard to targeting the population for congregate housing, this in turn has an impact on cost benefit.

Maine very much targets congregate housing to people most at risk of institutionalization.

This is done when PAC's use the following criteria when considering program applicants. First, applicants must be impaired in at least four ADL or IADL activities. This compares with only two ADL impairment requirements in the HUD program. Second, applicants must lack an adequate family or other social support system to provide for their needs. Finally, applicants must have a need for at least two core services and case management. Because of this criteria, the focus of the Maine program is very much toward targeting the highly vulnerable, and the experience has been that the program serves the very frail.

So professional assessment committee services and criteria are key to screening appropriate applicants for the program. Congregate Housing Program must also make available onsite core services which include meals, housekeeping and personal care services. None of these services are mandated. All are provided as needed by individuals in accordance with a care plan. Home health services, including nursing, OT and PT services, are provided through local home health agencies.

Finally, under State regulations for congregate housing each program must offer a case manager. The case manager is a professionally trained person who is responsible for managing the delivery of services to tenants.

On the State level the Congregate Housing Services Program is administered by the State unit on aging, the Bureau of Maine's Elderly. The bureau is responsible for administering State funds and for certifying and monitoring local programs. The bureau works very closely with State and Federal housing finance agencies to coordinate the approval, development and operation of Congregate housing facilities.

On the local level, congregate services programs are the responsibility of either local area agencies on aging or housing owners, which are grantees of State service funds.

Relative to the cost of congregate housing, attached to my testimony is a chart which was prepared in 1984 and which looks at

costs at eight congregate housing sites. The chart also compares the cost of those eight sites with the costs of boarding care and nursing home care in the State of Maine.

Congregate housing is obviously far less costly than nursing home care. While comparable in cost to boarding homes, the congregate housing alternative is viewed as far more desirable by older people.

Maine now has 15 operational congregate housing programs for low-income elderly. Unfortunately, there are only two private programs in the State. These two programs offer rents in the range of about $1,000 a month and there are long waiting lists at both sites. This is unfortunate. In Maine and throughout the New England area then is a critical lack of opportunities for middle-income older people to participate in congregate housing programs. I think this scarcity is important to recognize, and I suggest why in my testimony.

In both the public and private sectors I think there are barriers to expanding congregate housing. The development of publicly supported programs is restricted by shrinking housing resources and limited services funding. In the wake of tremendous cuts in subsidized-housing programs for the elderly, efforts to establish congregate housing have been restricted.

A second major barrier has been limited availability of services funds. Few States fund congregate services programs. States simply do not have the financial resources to undertake a program of this nature.

In the private market opportunities are extremely limited. I can only speculate on why private congregate housing opportunities are limited. I think in part it is due to a general lack of knowledge of the concept of congregate housing and also a lack of know-how relative to developing and operating this form of housing.

I would make several recommendations for Federal actions related to congregate housing. First, I think the Federal Government must maintain some funding for housing programs for the elderly. If you are to continue the HUD 202 and the public housing programs and the Farmers Home 515 Program, as I think you should, then I believe that under these programs there should be a set-aside of funds for congregate housing proposals.

In addition, I think the Federal Government should maintain tax provisions to finance housing through the sale of tax exempt bonds.

I also think Federal mortgage insurance programs should be maintained and, again, under any Federal housing program that could assist the elderly I think there should be a priority given to funding congregate housing proposals.

Finally, I concur with the recommendation to fund the Congregate Services Program through a joint Federal and State partnership. In view of the considerable financial pressures on both Federal and State governments, I think it is unlikely that Washington alone or the States alone would fully fund a Congregate Services Program. I think the cost savings to both the Federal Government and State governments are obvious and I think for that reason——

Mr. BONKER. Are what?

Ms. GARDNER. Obvious.

Mr. BONKER. Not to some people.

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Ms. GARDNER. To myself, to people in Massachusetts, to people in St. Paul, to many in the field of long-term care and congregate housing, I think it is obvious, and for that reason I think that both the Federal and State Governments should participate in a joint program to fund congregate services.

Thank you very much.

[The prepared statement of Ms. Gardner follows:]

TESTIMONY OF ANNE M. GARDNER, HEALTH CARE MANAGEMENT ASSOCIATION, INC., LYNNFIELD, MA

INTRODUCTION

I am pleased to have the opportunity to appear before you today to discuss some of the state and private initiatives in the area of congregate housing. In my testimony I will describe examples of non federal approaches to developing congregate housing and will examine some of the barriers to expanding congregate housing opportunities. I will conclude my remarks by recommending some federal actions designed to increase the supply of congregate housing for the elderly.

EXAMPLES OF STATE AND PRIVATE MODELS OF CONGREGATE HOUSING

While only a handful of states have developed congregate housing programs, New England has the distinction of offering several. In Maine, Massachusetts and Connecticut, congregate housing programs are funded and administered by the state. Programs in these states have grown steadily in recent years as legislators, consumers and practitioners have supported congregate housing as a successful residential long term care program. As former Director of Housing for the Bureau of Maine's Elderly, where I was involved in the design and implementation of Maine's congregate housing program, I will describe Maine's program as an example of a state's approach to developing congregate housing.

MAINE'S CONGREGATE HOUSING PROGRAM

In 1980, Maine enacted legislation establishing a demonstration congregate housing program for the elderly. The law defined congregate housing as "residential housing consisting of private apartments and central dining facilities and within which supportive services are provided to functionally impaired elderly who are unable to live independently, yet do not require the constant supervision and/or intensive health care available at intermediate or skilled nursing facilities."

The law provided state funds for social and health services programs at two demonstration congregate housing sites. Funds for the construction and operation of the housing facilities had previously been committed by the Maine State Housing Authority and the State Office of the farmer's Home Administration. In creating a demonstration program, Maine was interested in testing congregate housing as a high quality, cost effective program when compared with boarding and nursing home options.

Demonstration results were impressive. Fully 22% of older people who moved into congregate housing relocated from nursing homes or boarding homes. Relative to cost, it was found that the average monthly cost of congregate housing was $767 compared with an average monthly nursing home cost of $1,362. For those older people who relocated from nursing and boarding homes, the congregate housing option offerd a far more desirable alternative than institutional care.

As a result of the success of the demonstrations, in 1983 new legislation was enacted to transform the demonstration status of congregate housing to a permanent state program and to expand funding for additional programs. Recent 1985 action by the legislature will triple the state's supply of congregate housing over the next two years.

Let me briefly describe how Maine's program works. As with all congregate housing programs, the Maine model has effectively combined a housing program with a services program.

THE HOUSING

All of Maine's congregate housing facilities are federally subsidized complexes developed under Farmer's Home or HUD housing programs. The facilities offer standard design features of housing for the elderly and rent subsidies available at most

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sites ensure that tenants pay no more than 30% of their income for rent. Most of the state's congregate housing facilities offer private, full equipped apartments within building containing central dining, kitchen and lounge areas. Within these apartment complexes, which range in size from 40 to 60 apartments, 20 to 30% of the units are designated and reserved for impaired elderly who require on-site congregate services. The remainder of the apartments are occupied by "independent" functioning tenants.

Monitoring of the design, development and management of the state's congregate housing facilities is carried out by the HUD or FmHA agency under which the housing is financed. These facilities are owned and managed by non-profit as well as for-profit sponsors.

THE SERVICES

Complementing the housing facilities, each congregate housing project offers a comprehensive congregate housing services program (CHSP). Standards for Maine's CHSP's are outlined in law and defined in state regulations.

There are four basic elements common to Maine's CHSP's. First, each program establishes a professional assessment committee (PAC) which is responsible for determining an elderly person's eligibility for the program. Congregate housing PACs generally include the project housing manager, a case manager from the area agency on aging and a nurse from the local home health agency. Committee members use established assessment procedures and criteria for determining eligibility for the program. On an ongoing basis, PACs monitor the appropriateness of services delivered to tenants, periodically reassess tenants, and, when necessary, terminate tenants from the program.

Second, each program offers the availability of "core" services which include meals, housekeeping and personal care. Most sites provide noontime meals, seven days a week, and offer meal preparation assistance to individual tenants as needed for other meals. Housekeeping services are generally provided by congregate housing services aides based at the sites. Personal care services are provided by trained aides from local home health agencies.

Third, programs offer home health services including RN, OT, PT and home health aide services through local home health agencies. The home health agency nurse who is a member of the Professional Assessment Committee is responsible for assessing tenant's nursing and home health needs and arranging for the delivery of health services.

Finally, each program offers a congregate housing case manager. The case manager is a professionally trained person who is responsible for the overall management of the delivery of services to congregate housing tenants. For each congregate housing tenant, the case manager, in conjunction with the tenant and other members of the PAC, develops a specialized plan of care outlining the types and amounts of services needed and how services will be provided. The case manager then arranges for and monitors the delivery of services to tenants. As the status of the tenant changes, the case manager adjusts the services plan accordingly. Services secured by the case manager include formal on-site core services, informal services provided by family, friends and other tenants and other community services.

It is the very important function of the case manager to individually tailor a service plan for each congregate housing tenant. In doing so, congregate housing is able to respond to each tenant's needs and preferences and provides a very noninstitutional approach to long term care.

On the state level, the congregate services program is administered by the State Unit on Aging, the Bureau of Maine's Elderly. The Bureau is responsible for administering program funds and for certifying and monitoring local programs. The Bureau works closely with state and federal housing finance agencies to coordinate the approval, development and operation of congregate housing projects.

On the local level, area agencies on aging or housing owners, as the grantees of state CHSP funds, are responsible for the over sight of the operation of local congregate services programs. Grantees provide case management services to congregate housing tenants and subcontract with community agencies, or directly deliver, other services (meals, personal care, housekeeping, etc.) needed by tenants.

The chart attached to this testimony shows the 1984 costs of eight of Maine's congregate housing programs. It also compares the costs of congregate housing with Maine' nursing home and boarding home programs.

The chart shows that congregate housing is very cost effective when compared with nursing home care. While comparable in cost to boarding homes, the state

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share of costs is far less for congregate housing than for boarding homes and the quality of congregate housing is perceived as far greater.

The cost effectiveness and quality of congregate housing has made this alternative successful and popular in Maine. This success is now reflected in state policy which is curbing the growth of nursing and boarding homes while actively working to increase the supply of congregate housing.

PRIVATE CONGREGATE HOUSING PROGRAMS

In contrast to Maine's 15 operational congregate housing programs for low income elderly, only two programs in the state offer congregate housing for middle income older people. At one site, Clover Living Center in Auburn, 44 units of congregate housing were attached to a nursing home. By coordinating staff and services administered by the nursing home, congregate services are delivered to the apartment complex in a cost effective and efficient manner. At a second site in Portland, the Park Danforth, a non-profit sponsor, recently opened 106 units of congregate housing. 70 units were developed under the HUD 202 Program and 36 private units were developed using conventional financing. The cost of congregate services for tenants in the HUD units is being met through tenant fees and the sponsors' endowment funds. On the market side, rental fees support the full cost of the program.

The Auburn and Portland programs, where rents are in the $1,000/month range, are unable to meet local demand and each site has a substantial waiting list. The experience of these two programs, as well as other private programs in New England, attests to the private demand for congregate housing. While this demand appears strong, unfortunately, in the New England area, there is a critical lack of congregate housing opportunities for middle income older people.

The scarcity of congregate housing opportunities in the private market is important to recognize. Lack of this option precludes a significant number of private paying nursing home residents and home care clients from the choice of relocating to a less expensive, and often more desirable, residential setting. In more expensive institutional and home care settings, many private paying clients will spend down to Medicaid levels at an accelerated rate and will consequently require public support. Programs such as congregate housing which have the potential to slow or prevent the spend down of private clients should be promoted as sound public policy.

BARRIERS TO EXPANDING CONGREGATE HOUSING

In both the public and private sectors there are barriers to expanding the supply of congregate housing.

Publicly supported programs are faced with shrinking housing resources and limited services funding. In the wake of tremendous cuts in subsidized housing programs for the elderly, Maine's efforts to establish congregate housing have been restricted. Consequently, rather than develop new congregate housing facilities and services programs, the state has begun to direct congregate services funds to existing elderly housing sites. Under this model, existing housing is "converted" to congregate housing. While this approach is workable in many areas, a number of Maine communities do not have existing housing facilities which are suitable for congregate housing conversion. As an example, elderly housing in many rural communities has been designed as two story walk up buildings with detached community centers—a design clearly not suitable for a congregate housing program or population. A second barrier to the conversion of existing housing is that a number of housing owners do not wish to participate in sponsoring a congregate services program. In deed, congregate housing is more complex and more staff intensive than independent elderly housing and it is therefore viewed by some housing owners as an unattractive program for development. The limitations of the congregate housing "conversion" model coupled with the lack of resources to finance new housing facilities, is constraining congregate housing expansion.

A second major barrier to the expansion of publically supported congregate housing is limited services funding. In Maine, where state funds are available, funding can not keep up with the need or demand. The state congregate services program has limited funds and the Bureau of Maine's Elderly has a backlog of acceptable program proposals.

The few states which fund congregate housing programs have limited resources. Most other states simply do not fund nor have the financial capacity to support congregate services programs at the level at which they are needed. On the Federal level, support for congregate services provided under HUD's CHSP program has been minimal.

In the private market, in the New England area at least, congregate housing opportunities are extremely limited. In part, this may be due to a general lack of understanding of the concept and of the "know how" relative to developing and operating this form of housing. Although some attractive financing mechanisms such as tax exempt bond financing is available to develop congregate housing for middle income older people, these programs have generally not been used for congregate housing in New England.

RECOMMENDATIONS FOR FEDERAL ACTION

1. Provide Federal Housing Resources for Congregate Housing Facilities.—If congregate housing opportunities are to expand, the federal government must maintain some funding for housing programs for the elderly. Efforts should be directed toward preserving or designing cost effective housing programs which can serve lower income older people. If programs such as the HUD 202 and Public Housing programs and the Farmers Home Administration 515 program are to be continued, as they should be, then under these programs there should be funds set aside or priority ranking for funding congregate housing.

In addition, the federal government should maintain tax provisions to finance housing through the sale of tax exempt bonds. Requirements to insure that a percentage of housing units financed by this method are reserved for low income persons should be maintained. Without providing expensive long term rental assistance payments, this approach is still able to achieve the important public purpose of housing low income elderly. Other Federal mortgage insurance programs should be maintained for financing congregate housing for middle income older people. Again, priority for funding under federal housing programs should be given to proposals to establish congregate housing.

2. Design a Mechanism to Fund Congregate Services Programs Through a Joint Federal State Program.—While the Congregate Housing Services Act of 1978 offered an important resource for funding congregate services programs, this model lacks the flexibility to significantly address the need for congregate housing. Because funds under this program are restricted to PHA and 202 housing sponsors, many existing elderly housing sites could not participate in the program. To illustrate the limitation of the program, in Maine most communities have neither local public housing authorities nor 202 housing, yet do have some form of federally assisted housing for the elderly. A practical congregate services program in Maine and elsewhere must have the flexibility to reach any housing development for the elderly financed under the Farmer's Home Administration or under the wide variety of HUD assisted programs.

The HUD program suffers not only from inflexibility but also from lack of support both within the administration and within HUD. In the past, the administration has repeatedly attempted to terminate the program and HUD has publicly stated that the program is unnecessary.

In view of these attitudes and in view of the considerable financial pressures on the federal government, it is unlikely that Washington alone will fund a congregate services program.

The state's response to funding congregate services programs has been equally restrained. The vast majority of states provide no funds for congregate housing and in the few states which support a program, service funding is limited.

A new approach is needed. An article in the spring issue of Generations recommends a Federal/State partnership to fund congregate services programs. As the article points out, federal and state governments should share the cost of congregate housing because they share the benefit. By forestalling the entry of low income elderly into nursing homes, the rate of increase of Medicaid expenditures—which are paid for by both federal and state governments—could be slowed. Savings in institutional care costs cold then be "recycled" into funding congregate services.

The federal government with its experience in the HUD CHSP program should provide leadership in designing a program for federal/state funding of congregate services. States would have clear cost savings incentives for participating in the program. Judging from the very positive, although few, state experiences to date, it could be expected that the program would be well received by the states.

Congregate housing is too important and too promising a long term care program to be restrained any longer. Its time has come and it needs and warrants the full support of both federal and state governments.

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MAINE CONGREGATE HOUSING COSTS

The following indicates the average monthly costs of services and housing for congregate housing tenants at eight state sites.

Site	No. 1	No. 2	No. 3	No. 4	No. 5	No. 6	No. 7	No. 8
Service costs [1]	$252	$254	$259	$235	$191	$196	$202	$239
Housing costs [2]	330	381	422	595	624	645	673	680
Total costs	582	635	681	830	836	838	875	919

[1] Include costs of all services (meals, housekeeping, personal care, transportation, nursing, case management, etc.) from all funding sources (State CHSP funds, Older Americans Act funds, Medicare/Medicaid, social services block grant funds, tenant fees, etc.)
[2] Reflects project fair market rents.

Costs Compared with Boarding and Nursing Homes.—The following are estimates of average monthly state, federal and client costs of nursing home care, "cost reimbursed" boarding home care and congregate housing in Maine.[1]

	Nursing home	Boarding home	Congregate housing
State share	$409	$397	$100
Federal share	953		518
Client share (including Federal SSI payments)		253	157
Total cost	1,362	650	775

Mr. BONKER. Thank you, Ms. Gardner. That was excellent testimony.

I would like to welcome my colleague, Mrs. Lloyd, on the committee, representing a district of the great State of Tennessee.

Do you have an opening statement or a delayed comment before I proceed to the last witness?

Mrs. LLOYD. I ask my remarks be included in the record.

[The prepared statement of Representative Lloyd follows:]

PREPARED STATEMENT OF REPRESENTATIVE MARILYN LLOYD

Mr. Chairman, as a member of the Subcommittee on Housing and Consumer Interests, I am fully supportive of the forum that our subcommittee is providing for the discussion of experiences under the Congregate Housing Services Program [CHSP].

The discussion is very timely and appropriate in view of the fact that the Congress is in the process of considering re-authorization of this program, which provides support services for frail elderly or handicapped persons living in lower income, Government-assisted housing.

I am very excited about the preliminary data on the program which indicates that it has been a successful and cost-effective alternative to institutionalization. According to this data, about one-fourth of elderly households in Federal assisted housing are unable to perform some routine, daily tasks that are required to maintain independent living. Without the support services provided by CHSP, the people in these households would be candidates for nursing homes. The cost of maintaining an individual in a nursing home is estimated to be three times higher than the cost of providing the necessary support services to the same individual in Government-assisted housing.

But, we're not just talking about dollars and cents here—we're talking about quality of life. I have yet to come across one person who, given a choice, would sacrifice their independence for an institutionalized life. I'm convinced from my own personal contacts with older people that they want to live as independently as possible.

[1] Figures assume individual living in boarding home and congregate housing receiving SSI and individual living in nursing home receiving Medicaid assistance.

It is a life style that is preferred, and it is a life style that is more economical and compatible with the independent spirit of our society.

Mrs. LLOYD. Mr. Chairman, I was at another hearing, but I certainly congratulate you for holding these hearings today. I think our commitment to enhance the quality of life for our seniors cannot be minimized. If we cannot seem to find all the answers, this is certainly a valid way of addressing the needs of our elderly citizens and provide, as you said, for more than mortar and bricks. We are really concerned about choice and quality of care, and it does help us to fit our financial constraints into the proper perspective.

Thank you, Mr. Chairman.

Mr. BONKER. Thank you very much, Mrs. Lloyd, for being here.

We now shall proceed with the last witness, Mr. Wooten Epes, who is the executive director of the Arkansas Development Finance Authority. We have now had Minnesota represented and Maine represented and Arlington, so we shall have Arkansas as well. He serves as the chairman of the elderly housing task force of the Council of State Housing Agencies. He also served as the city attorney for Helena. Is it Helena like the Montana's Helena?

Mr. EPES. Yes. But it is Helena, AR.

Mr. BONKER. And we are very pleased to have you with us today, Mr. Epes, and look forward to your testimony and trust you will be corroborating what the other witnesses have said on this panel.

STATEMENT OF WOOTEN EPES, EXECUTIVE DIRECTOR, ARKANSAS DEVELOPMENT FINANCE AUTHORITY, ON BEHALF OF THE COUNCIL OF STATE HOUSING AGENCIES

Mr. EPES. As you might say, I am in the cleanup spot.

Everybody else has covered many of the points we would like to address, but I will generally relate this to our position in the housing area. Again, in my role as the chairman of the Elderly Housing Committee for the Council of State Housing Agencies, I am glad to be here to address this topic.

The State housing finance agencies around the country administer over 200,000 units of section 236 housing which is publicly supported by section 8 rental assistance. State HFA's administer the housing assistance payments for those units, and approximately 15 percent of those units are occupied by elderly citizens.

It is important to us to address the problems that will be arising in those units by the aging in place phenomenon. In addition, though we are trying to address a broad spectrum of housing services for the elderly in areas outside of the congregate housing also, I will confine my comments today to our efforts in congregate housing.

The thing that we are aware of is that elderly citizens are more likely to be low income. In fact, in my home State we have about 40 percent of the elderly citizens who have incomes of less than $5,000, and it is very safe to say that there is not anywhere close to adequate assisted housing for that number of elderly citizens in need of housing.

That brings us to the issue of the gap that needs to be met here. This congregate program only addresses a small part of that gap,

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and that is to serve the elderly citizens that are already in assisted housing. We have approximately 10 percent of nursing home clients in my home State of Arkansas that could be housed in other types of arrangements, but for lack of an adequate arrangement they have to go to nursing homes because they do not have family or other support systems to help them through with their needs.

In the State housing agencies we have become aware of all of these needs and because of these realizations we recently were funded by HHS for a grant to work with the National Association of State Units on Aging to try to begin a networking of information with regard to the initiatives that are taking place around the country in elderly housing and particularly in the congregate housing area. A number of States in the New England area including Maine, Massachusetts and Connecticut, have been leaders in this area, and we hope to be able to use this grant to take experiences from States like that and apply it around the country to other areas.

One of the things that we hope to do is to apply a concept like this where you can take the capital resources of private housing markets to cover basic housing costs and then take the resources that are available in public assistance programs like Medicaid, Medicare and other social services to help provide the network of social services that the people need in their housing.

The membership agencies of CHSA have been active in this area. The States of Ohio, Illinois and others have been real active in it. One of the studies I think is notable is the Illinois Housing Development Authority study for the feasibility of congregate care housing, and they project a cost savings of $1,320 per person per year or $195,000 per year for the average-sized congregate facility per year. That is a significant savings over the cost of nursing home and other institutional care. The report concluded, "Unlike most long-term care facility residents, congregate housing residents retain control of their money, their personal affairs, their daily routine and the freedom to come and go as they please. Congregate housing promotes self-sufficiency, cost saving interdependence with friends and neighbors in the community, offsets social isolation and introduces costly professional support services only at the margin of individual need. For all these reasons, congregate housing is a timely and important housing option for the State of Illinois." I believe that addresses the issue of quality of life also that was mentioned in the study that was conducted by HUD.

Furthermore, I would like to point out that an addition is needed to this type of program into other areas of housing. We are generally in the area of tax exempt financing for housing where we bring in the private developers in the housing area, and we hope there will be some effort to extend that into some of the market rental units that can be used to network, as we have heard from Mr. Lawton earlier, our patchwork of services. I think the logical place for that to happen is at each State and each State unit on aging, coordinating with other health providers to try to provide those services.

I think it speaks for itself. I do not believe that there is any way to really question the fact that it is less expensive. We know that it costs in the vicinity of $1,200 per month for institutional care, and

many of the life care centers that people of the middle income groups are participating in are paying rents and service fees less than $1,200, so I know that we can work with a public-private partnership where we have some State subsidies, some Federal subsidies and we can bring those costs in at a substantially less figure than $1,000 and save several hundred dollars per person per month.

[The prepared statement of Wooten Epes follows:]

PREPARED STATEMENT OF WOOTEN EPES, EXECUTIVE DIRECTOR, ARKANSAS DEVELOPMENT FINANCE AUTHORITY, ON BEHALF OF THE COUNCIL OF STATE HOUSING AGENCIES

Mr. Chairman, my name is Wotten Epes, I am the executive director of the Arkansas Development Finance Authority. I am appearing today on behalf of the Council of State Housing Agencies [CSHA]. As the chairman of the CSHA Committee on Housing for the Elderly, I commend the chair for calling this important hearing.

CSHA's member agencies representing 49 States, the District of Columbia, Puerto Rico and the Virgin Islands, are primarily involved in providing adequate affordable housing to the low and moderate income Americans. Our involvement in this area has served to make us acutely aware of the increased proportion of elderly Americans who need housing. It is common knowledge that the American population is aging. Indeed in the previous decade, the over 65 population grew to 25.7 million so that by 1980 there were 16.5 million households maintained by a person over 65 years of age. Although a substantial number of these citizens owned their own residences (72% in 1979), the majority of those renting lived alone and were twice as likely to have incomes below the poverty level. Further the number of elderly occupied rental units comprised less than 30% of the total. Mr. Chairman, those demographics are frightening. For many of America's perfectly healthy senior citizens, institutionalization becomes the only resort.

As we in State housing agencies become aware of the increasing need for elderly housing, congregate housing seemed a very attractive idea. Not only does State subsidized congregate housing provide a more desireable life-style then nursing home facilities, it is less expensive. Studies indicate that congregate care facilities cost annually from $300-$6,000 per person less than do nursing homes. In this instance, the most desireable alternative is the least expensive.

These are the realizations which led to the Council of State Housing Agencies, under the farsighted leadership of John Bohm, its executive administrator to apply for and receive a grant from the Department of Health and Human Services. This grant enhances the collaboration of State housing finance agencies and State units on aging and improves their capability to develop housing options for older people. Received jointly with the National Association of State Units on Aging, the project grant funds has set four goals: to satisfy the information needs of State policy makers in elderly housing; to determine the "state of the art" on elderly housing and report on them; to draft, and field test a technical assistance document designed to improve State overall capacity to deliver a product which effectively integrated housing and support services for the elderly; and to disseminate knowledge and encourage participation through a series of showcase seminars.

In the housing industry it is fair to say, that there have been advancements in housing which provide the elderly with greater opportunity and choice in their living arrangements. These include accessory apartments, congregate care facilities, board and care, life care facilities, and in home care. Under a revised scenario which effectively combines the capital resources of the private housing market to cover basic housing cost and also utilizes resources such as Medicaid, Medicare payments and State funding to provide social services, the overall cost to the Federal and State governments could be reduced. It is also believed that the essential and effective integration of housing and social service funding could reduce the cost of housing to the consumer.

The membership agencies of CSHA have, in certain States, led the way in these and other housing innovations. Yet the extent to which these options have been adopted as a matter of public policy or a factor of the private markets response to elderly housing needs varies from State to State and locality to locality.

More importantly, the extent to which these alternatives have effectively integrated a sensitive and responsive package of services addressing the needs of the

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elderly over a longer term have, by most estimates, been minimal. Where linkages have been made, particularly in the area of congregate care, questions concerning the income levels of those being served and affordability of services is at issue. CSHA firmly believes that through more effective and efficient integregation of services this issue can be addressed.

As an example of how our States have responded to the housing needs or our senior citizens, I would like to being with what we are doing in Arkansas.

While we are studying the implementation of congregate care housing, we have enacted several programs that benefit elderly Americans. The Arkansas Home Equity Living [AHELP] allows our agency to purchase the homes of asset rich-cash poor elderly Arkansans. The homeowners retain life tenancy estates, and we, as owners consume all of the responsibilities of a landlord. This highly innovative program will afford elderly Americans the opportunity ot comfortably and without disruption age in place.

Further, the Arkansas Development Finance Authority utilizes portions of its tax exempt bond program to house seniors in multifamily apartments that charge substantially reduced rents.

As I mentioned, we are studying information which will be made available by the CSHA/NASUA HHS grant, the elderly housing activities of other States. Notable are the already active congregate care housing programs in Oregon and Ohio. The State of Oregon has met its responsibility to provide a continuum of care ot its aging. Run in conjunction with the Oregon elderly division, this program offers residence in complexes which provide an active lifestyle and such necessary services as meals, cleaning, and transportation. The average age of participants in the Oregon Congregate Care Program is 75.

In Ohio, the tremendous burden of nuring home care has led to the States approval of several congregate care housing developments. Already more than 2000 units of congregate care housing have been constructed. They are in developments which offer services that all include meals and transportation and a variety of options including: social activities, medical staff and cleaning. Like its counterpart in Oregon, the Ohio program serves tenants whose average age is 75 years.

These are clearly laudable programs that we in Arkansas hope to duplicate.

The Illinois Housing Development Authority [IHDA] recently commissioned the University of Illinois Housing Research and Development Program to study the feasibility of congregate care housing. That study, which compared seven congregate care facilities with seven "long-term" care facilities or nursing homes, noted that "congregate housing produced a cost savings of $1,320 per person per year, or $195,000 for the average sized congregate facility per year", and that there are numerous quality of life factors which favor congregate housing but cannot be quantified when comparing assisted independent living with dependent care.

The report concluded: "Unlike most long-term care facility residents, congregate housing residents retain control of their money, their personal affairs, their daily routine and the freedom to come and go as they please. Congregate housing promotes self-sufficiency, cost saving interdependence with friends and neighbors in the community, off-sets social isolation and introduces costly professional support services only at the margin of individual need. For all these reasons, congregate housing is a timely and important housing option for the State of Illinois."

IHDA is currently making the necessary preparations to institute a congregate care program.

Further, I would like to point out that State housing finance agencies are dependent on the availability of tax-exempt financing and other Tax Code incentives to induce private sector investors to participate in elderly and other low- and moderate-income housing programs. Your colleagues on the Ways and Means Committee are currently considering a tax reform package which would severely limit, if not cut off, our ability to do business. I urge the members of this committee to impress upon their colleagues the need to support the efforts of Reps. Heftel and Campbell to amend the tax reform proposal so that it is more favorable to housing.

Mr. Chairman, I hope my statement has clearly reflected the willingness and ability of State housing finance agencies to address a growing national need. It is clear that we, at the State level, cannot single-handedly house our senior citizens. We need the active support of the Federal Government. Initiatives such as the HUD congregate care demonstration programs are necessary, if not vital, to our effort. We urge your continued support.

Thank you for this opportunity, and I am ready to answer any questions this committee may have.

Mr. BONKER. Thank you, Mr. Epes.

While I must say that this panel has really provided us with useful information, I regret you did not testify first and then we could have gotten the administration to come forth and really try to reconcile what I see are inherent contradictions in the evaluation, that hopefully will make its way to the Hill within a month, and what all of you are telling us by way of your own experience and other reports that have been compiled on the same topic.

As a matter of fact, Ms. Anderson, you made reference on page 9 to, "Beyond the St. Paul CHSP cost experience, detailed and refined analyses are now being completed by a number of research institutions."

I would like to ask you and other members of the panel, if you know of other reports on the question of congregate housing, whether or not it is an alternative to institutionalized care, the cost benefits that are obvious to some and not obvious to others, I would be grateful if you could provide that information to the subcommittee staff because I think what I would like the staff to do—I have not discussed this with them, but I think as a result of this hearing and as we await the evaluation plus the administration's comments, I want the subcommittee staff to do our own evaluation on that report vis-a-vis the experiences that Ms. Anderson and others are apparently having, so we can present to the Congress a more comprehensive report on congregate housing because if that document becomes the only source of information on evaluating congregate housing, since it is still a demonstration project, I am not sure that we will have the benefit of truly objective information and, as a result, may make important policy decisions down the road.

It would be helpful to the subcommittee staff for those of you not only at the witness table but other interested parties, if you know of any information, regardless of what side of the issue, make it available to the subcommittee staff, I think we will prepare our own report.

I gather that all of you feel, as Mr. Eisenberg has noted, that the demonstration project on the congregate housing services program ought to be made permanent. Is there a sound of unanimity on the panel that we ought to make this a permanent program? Are we ready for it?

Mr. Eisenberg, as the original drafter.

Mr. EISENBERG. I really think we are. Again, there is an incentive for both the Federal Government and the State governments to enter into an arrangement with this type of permanent program. While there are States, as you heard here today, and localities that can take this kind of program on in one degree or another through their own resources, that is not true across the board; and the Federal Government has an important role, again with some self-serving interest, to encourage States and localities to broaden this. I think the experience definitely is there; that if you have somebody who you know would otherwise go off into some kind of institution, whether it be an intermediate care facility or a nursing home, it is better for the individual, better from a Government standpoint and it sure is better from a cost effectiveness standpoint to keep that person in home and familiar surroundings.

I do not see there is any reasonable other way to go unless somebody simply wants to throw away people and throw away money.

Mr. BONKER. What are we talking about in terms of costs? The original project is about $23 million.

Mr. EISENBERG. There is a cumulative figure of maybe $40 million over several years. I have lost track——

Mr. BONKER. Are we talking about a budget-busting program?

Mr. EISENBERG. Not at all. We figured at the time that this was put together in 1978 that to serve a universe of people in section 202 and public housing would cost, I guess, about $45, $50 million a year. We phased it in over time in the authorizing legislation. Of course, as we know so often happens here people are added to the program and money was not. The program originally was aimed at public housing and 202 was added on the floor of the Senate, and the dollars were not provided for that. But you figure maybe $45, $50 million in 1978 dollars to serve that entire population.

But, again, if as the individual experience bears out the cost savings in terms of avoidance of Medicaid type payments is on the order of 2 to 1 or 3 to 1, you have a program spending money in one budget function to save much more money in another budget function.

Mr. BONKER. OK. Well, I want to make sure I am clear that everybody at the witness table agrees we ought to make it a permanent program.

Ms. Gardner, yes or no?

Ms. GARDNER. I absolutely agree there should be a permanent, broad-based congregate services program. You might want to consider whether or not it should continue being housed in HUD.

Mr. BONKER. Where else?

Ms. GARDNER. Well, you could give——

Mr. BONKER. The Pentagon?

Ms. GARDNER [continuing]. HHS block grants to States. I have concerns about the lack of support and enthusiasm within HUD for the concept of the program. That has been long standing.

Mr. BONKER. Ms. Anderson.

Ms. ANDERSON. Definitely I feel a permanent program is needed. I think that in spite of the fact that HUD has not given a lot of verbal support to this program—a little understatement there—they have done a good job in getting this program operating. I would like to see HUD still have the main handle, at least with the money coming through or somehow. We found with HHS in block grants that the people in the highrises and public housing never see those services and money.

Mr. BONKER. Dr. Lawton.

Mr. LAWTON. Yes, I add my aye vote to this issue. I do think it is very important that we look at the demonstration in the spirit of what a demonstration is, that it had growing pains. I think the targeting issue, everyone would agree, is one of those areas that could be improved. I am so impressed with hearing of two programs that actually drew people out of nursing homes into the program. If we could add to that the many assessment programs that are going on in localities prior to admission to institutions, this is really the target population that we ought to be hitting; and I think that although it may be true, as the report says, that three-quarters of

the service people were not at high risk, that is one of those things that we needed to learn from the demonstration. And we could then proceed to chose more carefully those at high risk, then we can absolutely predict that those congregate services costs as compared to nursing home care can be reduced tremendously.

I would suggest that the HUD interpretation here in the Deputy Assistant Secretary's testimony is flawed though because in drawing attention to the three-quarters of the service recipients who are not at high risk, there is no reason to think there were not also three-quarters among the controls; and if we could preserve a 1.5 ratio of benefit, as one facet of the evaluation seems to suggest occurred, that would be a tremendous annual benefit.

Mr. BONKER. Thank you.

Mr. Epes.

Mr. EPES. Yes, sir, I definitely agree that the program should be continued and, in fact, I think my testimony will support the fact that it is very narrow in scope and there is a much greater need for it than it can serve.

Mr. BONKER. Mrs. Lloyd.

Mrs. LLOYD. I really do not think there is a lot to add to this, Mr. Chairman. I think the witnesses spoke quite eloquently and very knowledgeably. I would say in my home city of Chattanooga, TN, my church did a survey of what type of nursing home or facility for seniors was really needed, and they found that we are pretty well caught up with the needs of those who require institutional care. But in the areas we are addressing here today, we have not begun to scratch the surface in providing alternatives to institutional care. It is important that we do so—not only because of the cost factor, but for the quality of care as well. If this is true in Chattanooga, TN, I think it is probably true throughout our Nation.

Thank you.

Mr. BONKER. Well, thank you, Mrs. Lloyd, and thank you, witnesses, for coming today and helping to enlighten us on a very important program. We shall be in touch with you as we proceed to try to make a more permanent program, wherever lodged, that would continue congregate services. Your testimony has been very helpful.

The subcommittee is adjourned.

[Whereupon, at 12:15 p.m., the hearing was adjourned.]

APPENDIX

PREPARED STATEMENT OF THE AMERICAN ASSOCIATION OF HOMES FOR THE AGING

The American Association of Homes for the Aging (AAHA) commends the Subcommittee on Housing and Consumer Affairs for providing this forum to discuss the Congregate Housing Services Program (CHSP). AAHA appreciates the opportunity to highlight our members' experience with CHSP, which we believe is critically needed and has the potential of being one of the Department of Housing and Urban Development's (HUD) most effective efforts.

As the national representative of over 2,700 nonprofit facilities serving more than 500,000 older Americans daily with housing, health care, and community services, AAHA strongly advocates that a full continuum of care be accessible to older Americans. Availability of a range of services allows elderly individuals to secure the appropriate level of needed care and function at their highest degree of independence. AAHA believes that provision of supportive services to the elderly residents in federally assisted housing—services which enhance their ability to remain in independent living settings—is a legitimate component of a full spectrum of care and a cost-effective approach to meeting the needs of the elderly which should be maximized. Although HUD's final review and evaluation of the current CHSP has not yet been published, information exists showing the need for, as well as the cost-effectiveness and success of these demonstration projects.

RESIDENTS "AGING IN PLACE"

According to the Senate Special Committee on Aging's 1983 survey of the nation's 1,776 HUD Section 202 facilities, administrators estimated that 19 percent of their residents were "aging in place"; that is, they were becoming increasingly frail and in need of assistance with activities of daily living to avoid placement in more intensive care institutions. Frail residents in projects built under the original Section 202 program included 33 percent and 17 percent in those facilities built after 1973. However, AAHA questions whether these numbers reflect the full extent of current need, since administrators' responses may have been affected by HUD regulations imposing a 20 percent limit on the number of frail residents allowed in Section 202 facilities at any given time.

Similar findings were reported in a 1980 study, comparing the health and well-being of elderly residents in five federally assisted independent living projects 12 to 14 years after a comparable tenant sample was surveyed. Examining residents' ability to keep house, do laundry, cook, and bathe, it was found that 30 percent needed assistance: 21 percent were impaired in one or more of these activities, seven percent had two or more impairments, while two percent were impaired in three or four of these activities.

When originally surveyed, the average age of residents was 73; this increased to age 78 in the follow-up study. Those married decreased from 25 percent to only eight percent. The comparison study also noted a general decline in physical competence and well-being as reflected in increased number of hospitalizations and a lessening of such activities as leaving the neighborhood, shopping frequently, using public transportation, and going out after dark. Contact with children and other relatives decreased, as did seeing friends within the building.

More recent preliminary data from the CHSP demonstration projects estimates that about 24 percent of elderly households in federally assisted facilities are vulnerable or at-risk of institutionalization, since they are unable to perform a number routine, daily tasks.

CHSP: COST-EFFECTIVE AND SUCCESSFUL

About 50 percent of the current CHSP demonstration projects which are elderly housing facilities not sponsored by public housing authorities are AAHA members. HUD's report to Congress will contain an evaluation of their and the other grantees activities; however, highlights from one AAHA member's experience in the program indicate the strengths and achievements which we believe the final report will show as characteristic of CHSP.

Bethany Care in Haverhill, Massachusetts, was one of the first CHSP grants awarded and became operational in February of 1980. Under the terms of the grant, for three years Bethany Care would provide meals and support services to no more than 20 percent of the residents of Bethany Homes, a nonprofit Section 202 facility.

Through the competence and professionalism of its program director and staff, Bethany Care was able to lengthen the duration of its program through no-cost extensions, using monies not expended from the original contract. Two such no-cost extensions brought the program through the initial termination period of February 1983 to September 1984. Bethany Care sought and received additional monies appropriated by Congress to carry its CHSP through February 1985, and, again, a no-cost extension allowed the program to remain active through August 31, 1985. Recently, Bethany Care applied for additional funds from the $4.1 million appropriated this past session by Congress and, if awarded, these funds would continue the program through December 1986.

Bethany Care found CHSP's more appropriate, less-intensive care to be a very cost-effective alternative to institutionalization. Figures for the program show that costs for the 35 participating residents (including all costs of providing shelter and services) totaled $166,400 for one year. For one resident, this amounted to $4,750 per year which, when computed on an average cost per day, totals $13. The following chart summarized the annual costs experienced by Bethany Care in the final year of operation under its first grant:

COST SUMMARY

COSTS	Bethany Care	RENT	TOTAL (rent and care)
Total for 35 participants/year	$80,550.31	$85,896.00	$166,446.31
HUD payment	62,639.10	32,976.00	95,615.10
Residents' payments	17,911.21	53,920.00	70,831.21
Total for 1 participant for 1 year	2,301.44	2,454.17	4,755.61
Total for 1 participant for 1 day	6.20	6.72	13.03

Bethany Care estimated that 40 percent, or 14 of 35 participants in its CHSP project, would have required placement in more extensive care nursing facilities without the supportive services available through the program. A low estimate of the average cost of nursing care facilities in the Haverhill area in 1983 was $50 per day per person. Therefore, the more intensive care that would otherwise have been required by these 14 CHSP participants would have cost in excess of $297,000 per year, most of which would have had to be paid by the federal and state government under the Medicare and Medicaid programs. This $297,000 per year compares to a total cost for the 14 residents of only slightly more than $57,000 per year in Bethany's congregate services program and represents an overall savings for the 14 participants of $240,000 or $17,000 per person for a year.

While these savings are important, the human side of this program must not be overlooked. The opportunity for older Americans to remain in comfortable, familiar surrounding, pursuing, to the best of their ability, an independent life style, contributes to their sense of self-worth and dignity and enhances their quality of life.

By the middle of the next century, the number of elderly Americans will increase significantly. In the year 2050, one out of four Americans will be age 65 or over. Those individuals age 85-plus will increase sevenfold, from the current 2 million to 16 million people. CHSP offers an additional means for meeting current and expected needs of the elderly population at a cost to elderly individuals and public programs that is far less than current alternatives.

AAHA urges Congress to provide permanent reauthorization of CHSP. Furthermore, we urge that funding for the program be increased to a level that would, at

minimum, accommodate grants to enable older housing facilities for the elderly, constructed under the Section 8, 202, 236, and public housing programs—particularly those which have a significant and growing numbers of frail elderly residents—to provide needed supportive services that encourage individuals to remain in independent living facilities for as long as possible. Providing cost-effective housing arrangements to meet the needs of America's growing elderly population is not only sound public policy, it is necessary to assure older Americans the quality of life they clearly deserve.

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AMERICAN HEALTH CARE ASSOCIATION

Hearing on
The Congregate Housing Services Program Hearing
Subcommittee on Housing and Consumer Interests
House Select Committee on Aging

October 2, 1985

The American Health Care Association is the nation's largest federation of long term care facilities. Members of the association include licensed skilled and intermediate care facilities and licensed residential care facilities. The latter type of facility is licensed to provide personal care, such as assistance with eating, dressing, grooming and bathing to individuals who cannot maintain independence, yet do not require nursing care, such as that provided in a nursing home. Residential care is frequently a lower cost alternative for people similar to those served by the Congregate Housing Services Program. AHCA is pleased to offer these comments on the general issue of housing and support services for the elderly.

AHCA and its members are committed to the development of a long term care continuum. A broad range of services must be available and accessible. Without a continuum of care, inappropriate institutionalization of individuals will take place. The growing number of elderly persons and shrinking resources to fund their care mandates that every effort be made to match needs and services in the most efficient manner.

Within the long term care continuum comprehensive services range from one dimension services such as meals on wheels to 24-hour nursing home care. Residential care is a critical and valuable segment in the continuum of care. It provides housing and support services in one package. It is the link between independent living and nursing home care. Unfortunately, the value of residential care is often over looked by our public policymakers particularly federal ones, since it is not funded directly by federal funds. Instead, thought is given to devising new packages of services to combine with housing. AHCA recommends it would be best to look at what is already available before proposing new services or extending current demonstration programs.

It is our impression from the October 2, 1985 hearing, Congregate Housing Services Program, that you may intend to explore expanding the Congregate Housing Services Program (CHSP), which provides support services to residents of housing for certain elderly projects. There are a few major points AHCA recommends the Subcommittee consider when revising or expanding the program. They are outlined below. Many residents of housing for the elderly projects are developing the need for services beyond "bricks and mortar". Housekeeping, personal care, transportation and other services are necessary for some of these individuals to receive adequate care. However, AHCA would like to point out that residential care facilities which provide room, board and personal care to frail individuals are serving the same type individuals as CHSPs. Yet, these facilities differ from the CHSPs in four major areas:

1. Residential care facilities were not constructed with low interest HUD loans. Instead, they were constructed or acquired through the use of conventional financing. Many private investors and owners have risked capital to build these facilities.

2. Residential care facilities must be licensed. Sec. 1616(e) of the Social Security Act requires each state to establish licensing standards. Publicly funded housing for the elderly is not licensed. While state licensing requirements vary, most include standards for management, resident rights, social and dietary services, staffing, physical plant

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and record keeping. Facilities are annually inspected for licensure. This process enables state officials, consumers and other interested parties to determine whether or not a facility is in compliance with state standards. The process also results in costs to the facility, particularly when the requirements include substantial capital improvements, such as compliance with new fire safety codes.

3. Residents of residential care facilities have access to the state long term care ombudsman program, which is established under the Older Americans Act to assist residents with complaint resolution. This program provides an added level of protection against inadequate care. Residents of public housing for the elderly are not included in the ombudsman program functions.

4. Residential care facilities care for a substantial number of low income persons. These individuals rely on SSI federal benefits, which are often supplemented with state supplemental payments, to purchase care. The monthly federal payment level is $325.00. State supplements vary from $0 to $335 per month. Most combined federal and state benefits for people living in licensed residential care facilities amount to $400 to $450 per month, which is often inadequate. These SSI benefits are substantially lower than the cost of providing shelter and services under the CHSP, which averaged $204 per month, per person for meals and services alone. When the cost of the CHSP is added to the cost of housing, which is $300 + per month, it is clear that the cost of shelter and services under the CHSP is higher than the cost of licensed residential care. There are very few, if any, additional public funding sources for residential care facilities to enable them to provide care. In addition to the assistance provided under the CHSP, recipients of the CHSP are often recipients of additional federal and state benefits and programs such as food stamps, rent supplements, and fuel assistance. These assistance programs are not available to residents of residential care facilities, even though the income and needs of residential care facility residents may be the same as those residents of housing for the elderly.

In sum, while the CHSP may be successful, it is not the only, or even the most efficient vehicle for providing shelter and personal care services. When judging the success of the CHSP, it should be scrutinized and compared to residential care to determine which, if either, is best.

AFCA Recommendations

1. Any consideration to revise and expand the CHSP must recognize that the private sector counterpart, the licensed residential care facility, cares for similar people, usually for a lesser cost.

2. Any effort to increase funding for the CHSP to provide personal care and other services to individuals in housing for the elderly must be accompanied by a corresponding effort to increase Supplemental Security Income benefits for residents of licensed board and care facilities.

3. Using the CHSP to cite potential savings to Medicare and Medicaid funded nursing home and acute care should be avoided. These are not the only alternatives to housing for the elderly. Settings which include both shelter and services are often the logical step for individuals who cannot maintain independence. The CHSP is not the only program which can defer and deter inappropriate institutionalization.

In conclusion, AFCA is hopeful that the Subcommittee will take a careful look at all types of shelter and supportive services and the efficiency of the before it concludes that the CHSP is the only appropriate program to fill the gap between independent living and nursing home care.

STATEMENT OF KALLIA BOKSER
Coordinator, Office for the Aging, Community Affairs
New York City Housing Authority

Representing

The National Council on the Aging, Inc./National Institute of Senior Housing

Submitted to the
Subcommittee on Housing and Consumer Interests
Select Committee on Aging
U.S. House of Representatives

Mr. Chairman, I am Kallia Bokser, Coordinator of the Office for the Aging, Community Affairs, New York City Housing Authority. I am testifying today on behalf of the National Council on the Aging (NCOA) and its National Institute of Senior Housing (NISH) of which the authority is a member. Housing that meets the special needs of older persons has been an NCOA focus since its founding more than three decades ago. NCOA/NISH supports efforts such as the Congregate Housing Services Program (CHSP) that enable older people to remain living as independently as possible in the community.

I appreciate the opportunity to discuss with the subcommittee, NCOA/NISH's views based on the New York City Housing Authority's experience as a CHSP site. The Authority's program has demonstrated that bringing services into public housing - made possible by CHSP - enhances the quality of life of the elderly residents and prevents or postpones institutional long-term care.

Within the housing operated by the Authority the proportion of persons 75 and over has increased dramatically. Many residents have aged-in-place and others due to severe health or housing problems have been admitted as tenants. Without supportive services they could not remain living independently at home. Alternative living arrangements are not available in New York City and the availability of nursing home beds has been greatly limited. Confronted with this situation the Authority has explored various approaches and models to

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augment community-based services for this population. The CHSP model of early intervention in helping persons who require supportive services to maintain their independent living, and tailoring of services to the individual's needs has proven cost effective and very successful in meeting the needs of the frail elderly.

The following case example illustrates the benefits of CHSP. Mrs. X, age 83 maintained herself independently with the help of her husband until 5 months ago. At that time, Mr. X became ill and was hospitalized. Coming home from a visit to her husband, Mrs. X fell stepping down from a bus and broke her hip. After surgery and a joint replacement the doctor recommended that Mrs. X enter a nursing home for convalescence. Meanwhile, Mr. X was ready to be discharged and return home. When Mrs. X heard of this development she refused the relocation to a nursing home and informed the hospital personnel about services available (through CHSP) in her building. She insisted that it has the capability to take care of her and her husband. When this was confirmed by the hospital Social Worker, Mr. and Mrs. X were discharged and brought home. The CHSP Coordinator immediately set up a case management plan for each of them and their needs were taken care of. In her familiar surroundings Mrs. X who had become somewhat listless and disoriented in the hospital regained her mental faculties. With the assistance of the part time homemaker she learned to use the walker and soon took advantage of the congregate meals. Mr. X was served by staff as a homebound client until he was able to join the other program participants. Had the CHSP not been located at that site, Mr. and Mrs. X would have been in a nursing home and probably would never return to their own home where they will now probably live in dignity for the rest of their lives.

A very important aspect of the program which cannot be over-emphasized is its flexibility in providing services. It does not encourage client dependence, nor box everyone into the same service package. Those who need personal care receive personal care; others may only require the nutritious meals to prevent malnutrition and illness. Temporary participation in the program is permitted. In addition to the range of options provided for the elderly to accommodate the various levels of their impairment or frailty, they are not separated from their normal environment, their friends and family.

To contain costs the CHSP does not duplicate services provided by care-giver relatives nor those of the health and social networks of the wider community. Instead, the professional assessment committee (comprised of representatives from the aging network) and CHSP staff identify gaps in service, respond and fill the vacuum.

In assessing a similar program conducted by the Authority the findings dramatically showed that the frail elderly with supportive services could remain in their own home. By reinforcing their strengths and assisting wherever and whenever necessary to support their weaknesses, the rate of institutionalization was decreased. At least 20% of the frail elderly at the CHSP site would require costly nursing home placement had this effort not been initiated.

I can recount many examples of how the frail elderly consider the program as surrogate family concerned with every phase of their life. It was the hope of the CHSP providers that this would be expanded by an act of Congress after the demonstration period ends. Instead the funding for the program for FY '86 is very limited and each year its continuity is in jeopardy.

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On behalf of the National Council on the Aging/National Institute of Senior Housing, and especially those older adults currently in the New York City program, and the many who would greatly benefit from CHSP, I strongly urge this Committee to recommend legislation to authorize a permanent program and increase appropriations for the expansion of the program. It will reduce the expenditures for costly institutionalization and the total health care costs for the elderly. It ensures prolonged independence, reduces hospital admissions and enhances the satisfaction levels both of the elderly and staff caregivers who are not part of a complicated bureaucratic structure.

NCOA/NISH is prepared to work with the subcommittee and other members of Congress to ensure the continuation and expansion of a Congregate Housing Services Program. Thank you for the opportunity to submit our comments.

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